Summary Plan Description

NYU Retiree Medical Plan

Contents

Introduction

NYU offers three types of health plans to its retirees:

- ***traditional indemnity,***
- ***health maintenance organization (HMO), and***
- ***point-of-service (POS).***

Your choice of plans as a retiree will depend upon whether you and/or your covered dependents:

- are eligible for Medicare, and
- • reside in an HMO or POS service area. The traditional indemnity plan is called the NYU Retiree Medical Plan and it is offered to all retirees regardless of Medicare eligibility or residential area. This booklet is an overview of the NYU Retiree Medical Plan as well as a Summary Plan Description (SPD) for retired:

- Faculty (code 102),
- Administrators (code 100),
- Professional Research Staff (code 103),
- Office and Clerical Staff (code 106),
- Laboratory and Technical Staff (code 104),
- Sergeant Guards (code 107 PRG SGT), and
- Eligible Service and Maintenance Staff (code 107 who are in Local 810, Local 1 Security Officers Union, and non-union Service and Maintenance staff).

This SPD provides important information about who is eligible, what medical expenses are covered, how to file a claim, as well as additional administrative details. We urge you to read this booklet, share it with your family, and become familiar with the plan so you'll know how to proceed when you have a need for medical benefits.

Important Information Although this booklet contains a summary of the plan, you'll find complete information in the plan document. If there is any conflict between this booklet and the plan document, the document will govern. If you need more information, please contact the NYU Benefits Office.

NYU reserves the right to discontinue or change the NYU Retiree Medical Plan at any time. The plan is not an employment contract or any type of employment guarantee.

The Plan described in this booklet is a benefit plan of NYU. The benefits under this plan are administered by United HealthCare and are paid from NYU's funds.

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NYU Retiree Medical Plan Eligibility and Enrollment

You're eligible to continue health care benefits in retirement if you are an eligible employee who meets the age and service requirements described below.

WHO IS ELIGIBLE

You are eligible to participate in the NYU Retiree Medical Plan if you retire from NYU on or after January 1, 1989, were eligible to participate in one of the University's group health plans immediately before retirement, and are a member of one of the following six groups of employees:

- Faculty (code 102)
- Professional Research staff (code 103)
- Administrative and Professional staff (code 100)
- Office and Clerical staff (code 106)
- Laboratory and Technical staff (code 104)
- Sergeant Guards (Code 107 PRG SGT)
- Service and Maintenance staff (code 107 who are in Local 810, Local 1 Security Officers Union, and non-union Service and Maintenance staff).

AGE AND SERVICE REQUIREMENTS

Generally, you are eligible for retiree medical (and life insurance) coverage from NYU if:

- Your age plus years of continuous, full-time service equals 70 or more, and you are at least age 55 or older with at least ten years of service; or
- You were hired before September 1, 1991, completed 10 years of service before 9/1/1991, and you retire with 25 years of continuous, full-time service, regardless of age.

COVERAGE CATEGORIES

When you enroll in the NYU Retiree Medical Plan, you can cover yourself and the same family members (your spouse or registered same-sex domestic partner and eligible children) who were enrolled in your coverage for active NYU employees immediately before your retirement. The coverage category you elect stays in effect, unless you have a change in family status or your dependent child no longer qualifies for coverage.

There are three coverage categories:

1 Individual coverage: yourself only

2 Two-person coverage: yourself plus one (spouse or registered same-sex domestic partner, or eligible child)

3 Family coverage: yourself plus two or more (spouse or registered same-sex domestic partner and eligible children, or two or more eligible children) For information about eligible dependents, refer to –Covering Your Dependents".

HOW TO ENROLL

- You should contact the NYU Benefits at least 3 months before you plan to retire.
- • You must return a completed NYU Retiree Benefits Election Form to the NYU Benefits Office within 31 days of the date you retire and become eligible for NYU health plan coverage. (If you do not submit your enrollment form within 31 days of first becoming eligible, coverage will not be available to you. NYU will not accept late enrollments in the NYU Retiree Medical Plan under any circumstances.)

- You must indicate on this form whether you elect or waive coverage under one the NYU retiree health plan options available in your residential area.

  (If you waive NYU coverage because you enrolled in a non-NYU health plan you must provide the NYU Benefits Office with a copy of your health plan identification card. Later, if you choose to end coverage under the other health plan, NYU will permit you to opt back into the NYU Retiree Medical Plan (or NYU HMO plan if one is available in your residential area).

- If you elect to waive coverage, you can only re-elect the Retiree Medical Plan within 31 days of a Qualifiying Status Change. See Qualifying Status Changes.

Covering Your Dependents

You can enroll your eligible dependents for medical coverage.

YOUR ELIGIBLE DEPENDENTS ARE:

- Your spouse;
- Your registered same-sex domestic partner; and
- Your unmarried children through the end of the calendar year in which they reach age 19. Children include natural children, step-children, legally adopted children, and children placed for adoption.

OTHER IMPORTANT POINTS ON ELIGIBLE DEPENDENTS:

- You can cover your unmarried children through the end of the year in which they reach age 25 if they are full-time students at an accredited institution and they rely on you for support. If your child is under age 25 at the time he or she graduates from or leaves an accredited institution, coverage will terminate at the end of the month during which the graduation or leave occurs.
- Unmarried children over the maximum age for dependent coverage may be eligible for continued coverage if they are fully handicapped. A child is considered "fully handicapped" if he or she is unable to earn a living because of mental retardation or a physical handicap and depends chiefly on you for support and maintenance. Coverage may be continued for as long as the child is incapacitated, provided the coverage does not cease for any other reason. Proof that your child is handicapped must be submitted periodically to United HealthCare, the administrator of the NYU Retiree Medical Plan.
- Dependents are not eligible for coverage if they are in the military.
- Dependents are not eligible for coverage if they marry.
- If your spouse or registered same-sex domestic partner is an NYU employee or an NYU retiree and is eligible for the NYU Retiree Medical Plan or an NYU Medical Plan for active employees, and you have eligible children, your eligible children may only be covered under one plan – either your plan or your spouse‘s or same-sex domestic partner‘s.
- If your spouse or registered same-sex domestic partner is an active NYU employee and you have no eligible children, that spouse or same-sex partner will have coverage under an NYU Medical Plan option available to active employees and you will have individual retiree coverage under the NYU Retiree Medical Plan.
- If both you and your spouse or registered same-sex domestic partner are NYU retirees and you have no eligible children, you will each be covered at the individual level of coverage under the NYU Retiree Medical Plan.
- If you were employed in a Faculty/Professional Research/Administrative (codes 102, 103, 100) position for at least 10 consecutive years, and you die, your survivors are eligible for continuation of coverage under the NYU Retiree Medical Plan.

ENROLLING YOUR DEPENDENTS

You must indicate any dependents you wish to cover on your NYU Retiree Benefits Election Form, included in your NYU Retiree Benefits Kit.

Important You will be required to furnish proof of relationship in order to cover any dependents, if you have not already submitted proof. Proof of relationship is a copy of a marriage certificate, NYU Domestic Partner registration affidavit, birth certificate, final adoption papers, or documentation substantiating placement for adoption.

WHEN DEPENDENT COVERAGE GOES INTO EFFECT

If you have elected coverage for your spouse, registered same-sex domestic partner, and/or eligible children, their coverage under the NYU Retiree Medical Plan will start on the same date as your coverage.

CHANGING COVERAGE

You can change your coverage category by dropping a dependent(s) during the year if your dependent is no longer eligible for coverage. Your dependent may no longer be eligible when a change in family status occurs. Please refer to "What Is a Qualifying Status Change?" on the next page.

If you experience a qualifying status change, you can drop a dependent from your coverage, provided that:

- You notify the NYU Benefits Office within 31 days of the change in status and complete a new election form; and
- The adjustment you make is consistent with the status change.

New coverage will take effect as of the date the qualifying status change occurs. If you pay for medical coverage, your bill will be adjusted in the first billing cycle available after your change form is processed.

WHAT IS A QUALIFYING STATUS CHANGE?

- Your marital status changes (or you register or revoke a same-sex domestic partnership).

- You increase or decrease your number of dependents (birth, death, adoption or placement for adoption).

- Your dependent child is no longer eligible for coverage according to the terms of the plan(s) (exceeds age 19 or 25 if a full-time student or marries).

- A court decree that orders you must provide health coverage for your dependent.

- Your spouse‘s/domestic partner‘s work site changes.

- Your or your dependent‘s residence changes.

- Your dependent‘s Medicare/Medicaid eligibility status changes.

- Your spouse‘s/partner‘s employer‘s plan has a different plan year and open enrollment period than NYU‘s.

- Coverage under your spouse‘s/partner‘s plan is significantly curtailed or ceases.

- Your spouse‘s/partner‘s employer adds new health plan options.

- NYU adds new health plan options.

- Your spouse/partner commences or returns from an FMLA leave.

Note The term dependent refers to any of the following as defined by the plan: your spouse, your same-sex domestic partner that you have registered with the NYU Benefits Office, your child, your step-child, your adopted child(ren) or child(ren) placed with you for adoption, the child (ren) of your registered same-sex domestic partner.

Contributions

Participants in the NYU Retiree Medical Plan may be required to contribute toward the cost of coverage.

COST OF COVERAGE

The cost of coverage is determined annually, and if a change in contribution is required, you will be notified.

NYU reserves the right to require you to contribute to the cost of your retiree medical coverage and to increase your contributions in the future. If you are required to contribute to the plan, you will be notified of the cost in a separate communication.

How the NYU Retiree Medical Plan Works

The NYU Retiree Medical Plan covers a wide range of services and calculates its benefit based on reasonable and customary charges and maximum Medicare allowable charges. The plan is designed so that benefit payments are coordinated with Medicare.

R & C CHARGES

Only charges that are considered reasonable and customary for medically necessary services are covered under the plan. The reasonable and customary charge for a service or supply is the lower of the provider's usual charge for furnishing the service or supply or the charge United HealthCare determines to be the prevailing charge made for the service or supply in the geographic area where it is furnished. See Definitions for ~~"~~medically necessary."

In determining the reasonable and customary (R & C) charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of suppliers in the area, United HealthCare may take into account other factors such as:

- The complexity of the service or supply;
- The degree of skill needed;
- The type of specialty of the provider;
- The range of services or supplies provided by a facility, and
- The prevailing charge in other areas.

When a health care provider accepts Medicare assignment, the plan bases its payments on the Medicare allowance rather than on R&C charges. If a health care provider does not accept Medicare assignment, federal law places a limit on how much a physician can charge above Medicare's allowed charge—this is called the Medicare limiting charge. United HealthCare will use the federal limit applicable on the date of service to determine the payment you are due.

CALENDAR YEAR DEDUCTIBLES

You must pay a calendar year deductible of $200 each year for each covered person's eligible medical expenses before the plan starts making payments. After you've paid this amount, the plan will begin reimbursing you for some of your expenses. If you or a family member is covered by Medicare, the amounts used to meet your annual Medicare Part B deductible may also be used to meet your NYU Retiree Medical Plan deductible. For instance, if you pay the 2001 Medicare Part B deductible of $100, you need only pay an additional $100 to meet the NYU Retiree Medical Plan's individual deductible of $200.

The family deductible of $500 applies if you have chosen family coverage. If the combined deductible amounts paid by all your covered family members reach the family deductible amount, and at least one family member has satisfied the $200 individual deductible, no further deductible amounts need to be paid for the year. The plan will begin reimbursing you for eligible expenses for all covered family members. This applies to such expenses incurred on or after the date the family deductible is met for the calendar year.

If two or more covered family members are injured in the same accident, only one individual deductible must be paid for treatment of all family members' injuries.

COINSURANCE AND OUT-OF-POCKET LIMIT

After you have paid the calendar year deductible, you and the plan share any additional R&C covered expenses. Coinsurance is the percentage of these expenses that you and the plan pay. In most cases, the plan will pay 80% of covered expenses. The amount of coinsurance you are responsible for paying is described as follows:

- In determining how much reimbursement you will receive under the plan, the coinsurance will be applied only to the R&C charge for the service or supply; it will not be applied to the actual charge if this exceeds the R&C charge.

- The coinsurance maximum is the most you will have to pay for covered expenses each calendar year after you have paid the deductible. If you are also covered by Medicare, the coinsurance will be applied to the Medicare allowable charge, not the R&C charge. When the total you have paid for your coinsurance—including expenses used to meet the deductible—reaches $1,000, the plan pays 100% of all your R&C covered expenses for the remainder of the calendar year (or 100% of your Medicare covered expenses if you are Medicare eligible).

- The family coinsurance maximum limits the amount you have to pay for all of your family‘s covered medical expenses in a calendar year to $2,000. This includes expenses used to meet the deductible. When the total you and your covered family members have paid for coinsurance--including expenses used to meet the deductible-reaches $2,000, the plan will then pay 100% of all covered medical expenses incurred for the remainder of the calendar year for you and your covered family members.

- The individual out-of-pocket limit and the $2,000 family out-of-pocket limit apply to benefits subject to 80% coinsurance; therefore, these expenses count toward the out-of-pocket limit (for example: outpatient treatment of mental and nervous disorders).

LIFETIME MAXIMUM BENEFIT

The most that the plan will pay for any person in a lifetime is $1,000,000.

This maximum may be restored in full each January 1 up to the amount of benefit payments you received or $1,000, whichever is less. For example, if you incurred $5,000 in claims during the previous plan year, only $4,000 would be applied toward the lifetime maximum. If you incur only $500 in claims during the previous plan year, however, no amount will be applied toward the lifetime maximum.

Note: Under the restoration feature of the plan, if you reach the lifetime maximum during the plan year and incur additional expenses for that year, the $1,000 restoration amount will only apply to expenses incurred during the next plan year.

NON-OCCUPATIONAL COVERAGE

Only non-occupational injuries and illnesses are covered under this plan. Work related injuries and illnesses, even if they continue in retirement but were incurred while employed, are Workers' Compensation expenses to be submitted to the Workers' Compensation Plan of the employer at the time the injury or illness occurred.

MEDICARE

If you and/or your covered dependent is eligible for Medicare, the plan will coordinate your benefits with Medicare. It is important that you enroll for Medicare benefits when you first become eligible. For example, when you reach age 65 and become eligible for Medicare due to age, the NYU Retiree Medical Plan provides secondary coverage. That means it bases plan payments on what Medicare pays first — even if you have not applied for Medicare.

Medicare is divided into two parts—Part A for hospital benefits and Part B for other medical expenses. You make no contribution toward Part A hospitalization coverage; however, you must pay a premium for Part B. You must also pay a deductible before Medicare pays Part A and Part B benefits on your behalf. The 2011 deductible for Part A hospitalization is $1132 and for Part B coverage is $162.

For an explanation and examples of how the plan coordinates payments with Medicare, see ***How the Plan Coordinates With Other Plan.***

Your Hospital Benefits

The NYU Retiree Medical Plan will pay 80% of most reasonable and customary hospital charges, after you pay the deductible. If you are eligible for Medicare, plan payments are reduced by the amount Medicare pays (or is scheduled to pay) for covered services on your behalf.

HOSPITAL BENEFITS

You are covered for certain expenses you incur during a stay in the hospital, including:

- Semiprivate room and board charges;
- Medically necessary hospital services and supplies; and
- Physician's services for administering anesthetics.

These charges are treated as all other covered expenses—the plan pays 80% after you have satisfied the deductible.

When you reach the out-of-pocket limit (see page 11), the plan pays 100% of covered expenses.

MATERNITY HOSPITAL STAYS

Under federal law, group health plans and insurance organizations may not restrict the hospital length of stay for a new mother to less than 48 hours for a normal delivery and 96 hours for a cesarean delivery. In addition, the plan may not require a provider to seek authorization in order to prescribe a length of stay that is not in excess of 48 or 96 hours.

Alternatives to a Hospital Stay

Treatment in a convalescent facility, hospice facility, a birthing center, or through home health care can be an effective and less costly alternative to a hospital stay.

COVERED CONVALESCENT FACILITY CHARGES

After you meet your deductible, the NYU Retiree Medical Plan will pay 80% of the eligible reasonable and customary (R&C) charges at a convalescent care facility.

- The stay must begin within 14 days following a hospital stay of at least three consecutive days.

- The maximum period for covered convalescent care is 365 days per "convalescent period."
- All convalescent care will be considered part of one period unless 90 consecutive days have passed since confinement in any facility providing nursing care. Covered expenses include medically necessary R&C charges for:

    - Room and board. Charges for daily room and board in a private room are covered up to the semiprivate room rate;
    - Use of special treatment rooms;
    - X-ray and lab tests;
    - physical, occupational, or speech therapy;
    - oxygen and other gas therapy;
    - and other medical services normally provided by a convalescent facility (but not including private duty nursing services, special nursing services, or physician's services); and
    - Drugs, biologicals, solutions, dressings, and casts (but not other supplies).

Note Covered expenses for convalescent facility care do not include charges related to drug addiction, chronic brain syndrome, alcoholism, mental retardation, or senility.

HOME HEALTH CARE BENEFITS

After you meet your deductible, the NYU Retiree Medical Plan will pay 80% of covered expenses for medically prescribed home health care services provided by a licensed home health care agency in accordance with a Home Health Care Plan, including:

- Part-time or occasional nursing care by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) if a registered nurse is not available;

- Part-time or occasional home health aide services primarily to care for the patient (but not custodial care);

- Physical, occupational, and speech therapy; and

- Medical supplies, drugs, and medicines prescribed by a physician; laboratory services

provided by a home health care agency (but only if they would have been covered under the plan if the individual had been confined in a hospital or convalescent facility).

Note The NYU Retiree Medical Plan covers a maximum of 200 visits for home health care services per calendar year. Each visit by an R.N., L.P.N., or therapist, and up to four hours for a home health aide is considered one "visit."

Certain home health care services *are not* covered under the NYU Retiree Medical Plan. These services include:

- Custodial care;
- Help provided by a person who lives in your home or who is a member of your family or your spouse's or registered domestic partner‘s family;
- Services for social work; or
- Transportation.

HOSPICE CARE BENEFITS

A hospice facility offers a coordinated program of home and inpatient care for terminally ill persons and their families.

Note The NYU Retiree Medical Plan covers R&C charges for full-time inpatient care for up to 210 days.

Under Medicare's expanded hospice benefit, the previous 210-day limit on the hospice benefit is eliminated if the beneficiary is recertified as terminally ill by the medical director or the physician member of the hospice program. This expense is paid at 100% of R&C charges without a deductible. Outpatient hospice agency services are paid at 100% of R&C charges without a deductible. Treatment must be authorized by a licensed physician for the following services:

- Inpatient hospice, hospital, or convalescent charges (as part of a hospice care program) for room and board and other services for pain control or symptom management, up to the R&C charge for a semiprivate room;

- Services and supplies furnished by a hospice while the person is not an inpatient;
- Part-time or occasional nursing care (through a hospice care agency) by an R.N. or
- L.P.N. for up to eight hours each day;
- Part-time or occasional home health aide care of the patient for up to eight hours each day;

- Medical social services;

- Psychological and dietary counseling;

- Bereavement counseling, up to five visits;

- Physicians' consultation or case management services;

- Physical and occupational therapy; and

- Prescribed medical supplies, drugs, and medicines.

The NYU Retiree Medical Plan does not cover funeral arrangements, pastoral counseling, financial or legal counseling related to estate planning, or caretaker services not solely for the patient (for example, respite benefits).

BIRTHING CENTER EXPENSES

After the deductible has been paid, the NYU Retiree Medical Plan pays 80% for charges made by a birthing center for the following services and supplies:

- Prenatal care;
- Delivery of a child or children; and
- Postpartum care rendered within 24 hours after the delivery.

Expenses that would not be covered in a regular hospital would not be covered in a birthing center. For a definition of ~~"b~~irthing center", see Definitions.

Your Surgical Benefits

Most surgeon's fees and related charges are paid at 80% of reasonable and customary charges, after the deductible.

Covered charges include surgery performed by the operating physician for these procedures:

- Incision, excision, or electrocauterization of any organ or part of the body;
- Manipulative reduction of a fracture or dislocation;
- Suturing of a wound;
- Removal by endoscopic means of a stone or other foreign object from the larynx, bronchus, trachea, esophagus, stomach, urinary bladder, or ureter;
- Anesthesia administered by the anesthesiologist.

ELECTIVE SECOND SURGICAL OPINION

Getting another opinion for any kind of surgery makes sense. If you wish to receive another opinion for a covered surgical procedure under the NYU Retiree Medical Plan, the NYU Plan will cover another opinion like any other medical expense at 100% (of reasonable and customary charges) and the deductible is waived. You decide whether to proceed with surgery.

Other Covered Health Care Servicesand Supplies

In addition to the expenses already mentioned, the NYU Retiree Medical Plan covers many other medical expenses including physician's fees, lab tests, X-rays, and prescription drugs.

After you meet the deductible, the NYU Retiree Medical Plan will pay 80% of reasonable and customary (R&C) charges for the following covered services and supplies. Keep in mind that plan payments are reduced by the amount Medicare pays (or is scheduled to pay) for covered services on your behalf.

- Charges made by a physician, including physician office visits;

- Charges made by an R.N. or L.P.N. or a nursing agency for skilled nursing care. As used here, "skilled nursing care" means visiting nursing care by an R.N. or L.P.N. –Visiting nursing care" means a visit of not more than two hours for the purpose of performing specific skilled nursing tasks;

- Prescription drugs and medicines through the Plan's retail prescription drug program or mail-order program, both of which are administered by Caremark, Inc.;

- Diagnostic laboratory and X-ray examinations used to diagnose an illness or injury;

- X-ray, radium, and radioactive isotope therapy;

- Anesthetics and oxygen;

- Rental of durable medical and surgical equipment;

- Artificial limbs, prostheses after mastectomy, and artificial eyes (but not eye examinations, eyeglasses, hearing aids, orthopedic shoes, or other foot support devices);

- Professional ambulance services when medically necessary;

- Sterilization and reversal of sterilization; and

- Charges for speech therapy, when therapy is expected to restore speech as a result of a disease or injury and for injury and for developmental delays because of congenital abnormalities, to a covered patient who has lost the existing ability to express thoughts, speak words, and form sentences, up to age three.

Benefits for Special Conditions

The NYU Retiree Medical Plan also covers inpatient and outpatient treatments for special conditions. These benefits cover alcoholism, drug abuse, organ transplants, mental disorders, conditions of the spine, physical therapy, acupuncture, and mammography. Plan payments are reduced by the amount Medicare pays (or is scheduled to pay) for covered services on your behalf.

INPATIENT TREATMENT OF MENTAL AND NERVOUS DISORDERS

Inpatient treatment of mental or nervous conditions is covered as any other inpatient hospitalization, up to a 730-day lifetime maximum benefit. (Amounts used for this benefit while an active employee will be used to reduce this maximum.) Care must be received in a non-governmental general hospital or psychiatric hospital. This coverage does not include treatment or detoxification for alcoholism or drug abuse.

OUTPATIENT TREATMENT OF MENTAL AND NERVOUS DISORDERS

The NYU Retire Medical Plan covers expenses for the outpatient treatment of mental and nervous disorders at 80% after the deductible, up to a maximum of 30 visits per calendar year.

Covered services include the professional fees of licensed physicians, psychologists, and certified social workers. This coverage does not include treatment or detoxification for alcoholism or drug abuse.

INPATIENT TREATMENT OF ALCOHOLISM OR DRUG ABUSE

Inpatient detoxification for alcoholism and drug abuse is covered at 80% of the R&C charge for up to 30 days per year. For alcoholism detoxification, each stay cannot exceed five days. Covered services must be received in a hospital or alcoholism or drug abuse treatment facility, which is an institution that:

- Mainly provides a program for diagnosis, evaluation, and effective treatment of alcoholism or drug abuse;

- Meets licensing standards;

- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological, and social needs, and must be supervised by a physician; and
- • Provides the following services on the premises 24 hours per day:
  - Detoxification services needed with its effective treatment program;

  - Infirmary-level medical services (also, the facility must provide, or arrange with an area hospital, any other medical services that may be required);

• Supervision by a staff of physicians; and Skilled nursing care by licensed nurses who are directed by a full-time registered nurse.

EFFECTIVE TREATMENT OF ALCOHOLISM OR DRUG ABUSE

–Effective treatment" means a program of alcoholism or drug abuse therapy that:

• Is prescribed and supervised by a physician, and includes a follow-up therapy program directed by a physician on at least a monthly basis.

• Includes meetings at least twice per month with organizations devoted to the treatment of alcoholism or drug abuse.

Effective treatment does not include detoxification (treatment of the after effects of a specific episode of drinking or drug abuse) or maintenance care (providing an environment free of alcohol or drugs).

Inpatient treatment charges incurred by a covered person while confined as a full-time inpatient in a hospital or treatment facility are covered for effective treatment of alcoholism and drug abuse.

Effective treatment of alcoholism or drug abuse on an inpatient basis is covered at 80% of the R&C charge for up to 45 days of confinement per year. This 45-day limit is reduced by the number of days of confinement for inpatient detoxification in the same year.

Outpatient treatment charges (incurred by a covered person while not confined as a full-time inpatient in a hospital or treatment facility) are covered for effective treatment of alcoholism and drug abuse. Benefits are paid at 80% of R&C charges for up to 60 visits per calendar year. Out of these 60 visits, up to 20 visits may be for counseling expenses directly related to the covered person's alcoholism or drug abuse for family members who live in the same home.

ORGAN TRANSPLANTS

After the deductible has been paid, the NYU Retiree Medical Plan pays 80% of R&C charges for medically necessary hospital services for organ transplants. Medically necessary hospital services for transplants, such as heart, heart-lung, pancreas, bone-marrow, and liver transplant procedures are covered as long as prior authorization is obtained from United HealthCare. You can obtain this authorization by calling 1-800-214-1736.

Coverage includes:

• All medically necessary inpatient and outpatient hospital services;

• Costs directly related to the procurement and donation of an organ used in the transplant procedure, such as donor lists, the surgical procedure necessary to procure the organ, storage expenses, and transportation costs, up to a maximum of $10,000 per transplant; and

• Reasonable travel expenses if the patient lives more than 75 miles from the transplant center, including food and lodging for the recipient and one family member (two if the

recipient is a minor). Travel expenses are covered to the location where the transplant takes place, up to a maximum of $150 per day with a $10,000 lifetime maximum benefit.

The benefit period begins five days before surgery and extends for a period of up to one year after the date of surgery.

Note There is a separate lifetime maximum organ transplant benefit of up to $1,000,000 per recipient. This maximum is separate from other benefit maximums under this plan.

TREATMENT OF THE SPINE

After the deductible is paid, the NYU Retiree Medical Plan will pay 80% of R&C charges for the cost of diagnosis and treatment of:

- Misalignment or dislocation of the spine; and

- Strained muscles or ligaments related to the spinal disorder.

Note Benefits are payable for up to 38 visits each calendar year, if they are medically necessary. The determination of medical necessity is made by United HealthCare. These limits do not apply to a person who is confined as a full-time inpatient in a hospital.

TREATMENT OF THE MOUTH, JAWS, AND TEETH

After the deductible has been paid, the NYU Retiree Medical Plan pays 80% of R&C charges for the following covered expenses for the treatment by a physician or dentist of teeth, mouth, jaws, jaw joints, or supporting tissue (bones, muscles, and nerves):

- Surgery needed to:
  - Treat a fracture, dislocation, or wound;
- • Cut out:
  - teeth partly or completely impacted in the bone of the jaw;
  - teeth that will not erupt through the gum; • other teeth that cannot be removed without cutting into bone;
  - the roots of a tooth without removing the entire tooth; or
  - cysts, tumors, or other diseased tissues;
  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal or repair of teeth.
  - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement;
- Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

- Dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition sound and natural teeth damaged, lost, or removed, or other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under this plan.

- Any affected teeth must be either free from decay If crowns, dentures, bridgework or in good repair and firmly attached to the jaw bone at the time of the injury. The treatment must be done in the calendar year of the accident or the next calendar year., or in-mouth appliances are installed due to such injury, covered medical expenses include only charges for:

The first denture or fixed bridgework to replace lost teeth;

The first crown needed to repair each damaged tooth; and
An in-mouth appliance used in the first course of orthodontic treatment after the injury.

The plan does not include the following charges:

- To remove, repair, replace, restore, or reposition teeth lost or damaged in the course of biting or chewing;

- To repair, replace, or restore fillings, crowns, dentures, or bridgework for nonsurgical periodontal treatment;

- For in-mouth scaling, planing, or scraping;

- For myofunctional therapy, which is muscle training therapy or training to correct or control harmful habits;

- For in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services except as provided for injury, whether or not the purpose of such services or supplies is to relieve pain;

- For root canal therapy or dental cleaning;

- For routine tooth removal (not needing cutting of bone), except as provided for accidental injury to sound and natural teeth; and

- For treatment of Temporomandibular Joint Syndrome.

INPATIENT PHYSICAL THERAPY EXPENSES

If you are confined as an inpatient primarily to receive:
- Physical therapy,
- Physical medicine, or
- Rehabilitation,

then R&C charges for these services are covered at 80%, after the deductible, for up to the first 30 days of full-time confinement in a calendar year. Other confinements not exclusively requiring physical therapy treatment are not subject to this 30-day limit and are covered at 80% after the deductible.

OUTPATIENT PHYSICAL THERAPY EXPENSES

After the deductible has been paid, the NYU Retiree Medical Plan pays 80% of R&C charges for physical therapy services given while the person is not confined as an inpatient in a hospital or other health care facility.

–Physical therapy" is medical rehabilitation treatment by physical means to improve or prevent further loss of a body function that has been lost or impaired as a result of a disease or injury. Such therapy must be given by a physical therapist as defined in this section.

This includes:

- Neuro-muscular massage;
- Heat treatment;
- Hydrotherapy; or
- Manipulation.

Benefits are payable for up to 33 medically necessary visits each calendar year.

A "physical therapist" is:

- A physician; or
- • A person who:
  - Is licensed as a physical therapist in the state or province in which treatment is given; or
  - In the absence of applicable licensing laws, is certified by the American Physical Therapy Association (APTA).

Outpatient physical therapy expenses do not include:

- Any services that have not been recommended by the person's attending physician;
- • Any services, which have not been provided in accordance with a specific treatment plan which:
  - Details the nature and duration of the treatment; and
  - Provides for on-going reviews and is renewed only if therapy is still needed;
- Speech or occupational therapy;

- Services rendered by a physical therapist who lives in the covered person's home or who is a part of the family of either the covered person or the covered person's spouse or registered same-sex domestic partner; or

- Supplies, and for any diagnosis or treatment not specified above as physical therapy services.

Note Benefits for physical therapy services will not be paid under any other part of the NYU Retiree Medical Plan.

ACUPUNCTURE EXPENSES

After the deductible is paid, the NYU Retiree Medical Plan will pay 80% of R&C charges, up to 14 visits each calendar year which are made for acupuncture services furnished to a person if they are provided by:

- A physician; or
- An acupuncturist certified by the American Association for Acupuncture and Oriental Medicine who is practicing within the laws of the jurisdiction where treatment is given.

Benefits are payable for up to 14 medically necessary visits each calendar year.

The service must be given:

- As a form of anesthesia in connection with surgery that is covered under this plan;
- To treat a disease or injury; or
- To alleviate chronic pain.

MAMMOGRAPHY EXPENSES

The NYU Retiree Medical Plan pays 80% of R&C charges, after the deductible, for mammography screening for occult breast cancer as follows:

- Upon physician's recommendation, a mammogram at any age for a person with a history of breast cancer or whose mother or sister has a history of breast cancer;
- One baseline mammogram for persons age 30 to 34;
- A mammogram every two years for persons age 35 to 39; and
- An annual mammogram for persons age 40 and older.

Prescription Drug Benefits

Effective January 1, 2011

When you enroll in an NYU medical plan, you automatically receive prescription drug coverage. Prescription drug coverage under the plan includes a retail prescription drug program and a mail service prescription drug service, both of which are administered by Caremark, Inc. Your copayment will depend on the type of drug you obtain:

- generic,
- brand-name medication on Caremark's Primary Drug List, or
- brand-name medication that is not on Caremark's Primary Drug List. Your copayment will be lowest when you choose a generic drug. If you obtain a brand-name medication from Caremark's Primary Drug List, your copayment will be lower than if you choose a brand-name medication that is not on the Primary Drug List.

A generic drug is a copy that is the same as a brand-name drug in dosage, safety, strength, how it is taken, quality, performance and intended use. It is less expensive because generic manufacturers don't have the investment costs of the developer of a new drug. Generic drugs look different from brand-name drugs because trademark laws do not allow a generic drug to look exactly like brand-name drugs. However, a generic drug must duplicate the active ingredient of the brand-name drug. Colors, flavors and certain other inactive ingredients may be different. Not every brand-name drug has a generic equivalent because brand-name drugs are generally given a patent protection for 20 years from the submission of a patent. Once the patent expires, other drug companies can introduce competitive generic versions, but only after they have been thoroughly tested by the manufacturer and approved by the FDA.

A Primary Drug List is a list of FDA-approved prescription drugs that are priced competitively for a therapeutic class of drugs. The brand-name drugs listed on Caremark's Primary Drug List are a preferred list of drugs that are selected based on their ability to meet patient needs at a reasonable cost. Caremark's Primary Drug List is updated quarterly. The Primary Drug List will be included in the booklet that you will receive from Caremark in December. To view Caremark's current Primary Drug List visit www.caremark.com.

Type	***Purchased at a Retail Pharmacy in the Caremark Network (30-day supply)***	***Purchased by Mail Service through Caremark (90-day supply)***	***Purchased by Mail Service through Caremark (180-day supply)***
Generic	$5	$10	$20
Medications on the Primary Drug List	$20	$40	$80
Medications not on the Primary Drug List	$35	$60	$120

Here are the prescription drug benefits provided to you under all the NYU medical plans:

Note 1: If you purchase a brand-name medication that is not on Caremark's Primary Drug List because there is no other brand on the market, you'll pay the Primary Drug List copayment, which is lower.

Note 2: If the cost for your generic or brand-name prescription drug is less than the copay, you'll pay the

lower dollar amount. For example, if the cost of a generic prescription drug is $3, you'll pay the $3 cost for the medication–not the $5 copay for generic prescription drugs, as specified under the plan.

Retail Prescription Drug Program

The retail prescription drug program is used for immediate drug needs or short-term medications. The retail prescription drug program offers you access to a network of over 55,000 Caremark participating retail pharmacies, including over 20,000 independent community pharmacies, which have agreed to provide prescription drugs to members at discounted rates.

Using a Caremark Participating Retail Pharmacy

Step 1. Call a Caremark Customer Service Representative at 1-800-421-5501 to find out if your prescription is considered "maintenance medication." If it is, you should use the Caremark's Mail Service Pharmacy (see the next page for the instructions).
Step 2. If your prescription is for immediate or short-term use, ask your doctor to write a prescription for up to a 30-day supply plus refills, when clinically appropriate. Step 3. Take your prescription to a Caremark participating retail pharmacy. Step 4. Present your Caremark ID card. Step 5. Verify that the pharmacist has accurate information about you and your covered dependents, including date of birth and gender. Step 6. Pay the appropriate co-payment.

There are no claim forms to file when you fill your prescription at a participating pharmacy.

Using a Non-Participating Pharmacy

Since Caremark's retail pharmacy network includes 98% of all "walk-in" pharmacies located in the United States, you should not need to visit a non-participating pharmacy. In the event you do go to a non-participating pharmacy, you will pay the full retail price for the prescription. You will then need to submit a paper claim form, along with the original prescription receipt(s) to Caremark for reimbursement. You'll be reimbursed for the discounted cost of the prescription— the cost the plan would have paid if the prescription had been filled at a Caremark participating pharmacy—less the applicable copayment. In most cases, the discounted price will be less than the retail price, so you may end up paying more when you use a non-participating pharmacy. The same applies in an emergency situation.

For example, if you paid $25 for a generic prescription drug at an out-of-network pharmacy and the plan's discounted cost for the same drug at an in-network pharmacy is $20, you'd be reimbursed for $15 ($20 minus your $5 copayment for a generic drug). The same applies when you go to a participating pharmacy and do not show your Caremark Prescription Drug ID Card or do not identify yourself to the pharmacist as a participant of the Caremark prescription drug program.

Caremark's Mail Service Pharmacy

Maintenance drugs are drugs that are prescribed for certain ongoing or chronic conditions (like high blood pressure or hypothyroidism) and are generally taken for long periods of time. Your doctor can predict your regular need for this kind of maintenance medication in advance. Caremark's Mail Service Pharmacy provides the lowest cost way to purchase such medications. Caremark's Mail Service Pharmacy allows you to buy a 90-day quantity of medication for the same amount you would pay for a 60-day supply at a retail pharmacy. Caremark's Mail Service Pharmacy should be your first choice when purchasing maintenance or long-term medications. (The number of times you can fill a maintenance prescription at a retail pharmacy is limited to two "fills" per calendar year. You will pay the full retail cost for a third and subsequent fills of your maintenance medication at a retail pharmacy. So you may want to "save" the allowance of two fills of a maintenance medication at a retail pharmacy in case of an emergency.)

Call a Caremark Customer Service Representative at 1-800-421-5501 to find out if that prescription is considered "maintenance medication."

How to Use Caremark's Mail Service Pharmacy

For new maintenance medications, ask your doctor to write two prescriptions: ● one, for up to a 90-day* supply plus refills, to be ordered through the Mail Service Pharmacy ● the other, to be filled immediately at a Caremark participating retail pharmacy for use until you receive your prescription order from the Mail Service Pharmacy. *Please Note: By law, Caremark must fill your prescription for the exact quantity of medication prescribed by your doctor, up to the 90-day limit. "30 days plus 2 refills" does not equal one prescription written for "90 days".

- Complete a Mail Service Order Form and send it to Caremark along with your original prescription(s) and the appropriate copayment for each prescription. Be sure to include your original prescription, not a photocopy.
- While checks and money orders are accepted, Caremark's preferred method of payment is by credit card. For credit card payments, simply include your VISA, Discover, MasterCard, or American Express number and expiration date, in the space provided on the Mail Service Order Form.
- You can expect to receive your prescription within 14 days of Caremark's receipt of your order. Your prescription will be delivered by First Class U.S. Mail or United Parcel Service (UPS).
- You will receive a new Mail Service Order Form and pre-addressed envelope with each shipment.

Mail Service Refills are Easy

Once you have processed a prescription through Caremark's Mail Service Pharmacy, you can obtain refills using the Internet, phone, or mail. Order your refill three weeks in advance of your current prescription running out. Suggested refill dates will be included on the prescription label you receive from Caremark.

- **Internet:** Visit www.caremark.com, your on-line prescription service, to order prescription refills or inquire about the status of your order. You will need to register on the site and log in. 27
- **Phone:** Call 1-800-421-5501 for Caremark's fully automated refill phone service.

- **Mail:** Attach the refill label provided with your last prescription order to a Mail Service Order Form. Enclose your payment with your order. Checks, money orders, and credit card payments are accepted. Do not send cash.

When you call or log in, be ready to provide: your ID number , your date of birth, your VISA, Discover, MasterCard or American Express , number with expiration date for your copayment

Money Saving Tips

If you want to obtain the lowest out-of-pocket cost for your prescriptions, you may want to ask your doctor about generic and brand-name medications from Caremark's Primary Drug List that are suitable for you to take. If your doctor feels a different drug from the same therapeutic class can work for you, you should have your doctor write a new prescription for that drug. Brand-name products that are on Caremark's Primary Drug List will reduce the cost of your prescriptions.

- Give your healthcare provider a copy of Caremark's Primary Drug List, which is in the booklet that you'll receive in December. The list can also be printed from www.caremark.com. Ask that brand-name medications from the Primary Drug List be prescribed for you if it is medically appropriate to do so.
- Have your healthcare provider indicate "may substitute" on your prescription to receive a generic (less expensive) product.
- Ask your healthcare provider to write a prescription for a 90-day supply so that you can fill your prescription by mail.

3 Ways to Contact Caremark with Your Questions

Internet: Visit www.caremark.com . To enter the site you will be required to register and log in. You can do the following:

- Prescription Refills
- Order Status
- Pharmacy Locations
- Benefit Coverage
- Request Forms
- Frequently Asked Questions
- 13-month Drug History
- Additional Health Information

Phone: Call 1-800-421-5501 to speak to a Caremark Customer Service Representative. Monday through Friday 7:00 a.m. - 9:00 p.m. (CST) and Saturdays 8:00 a.m. - 12:00 p.m. (CST).

E-mail: E-mail Customer Service at customer service@caremark.com.

Health Expenses That Are Not Covered

Although the NYU Retiree Medical Plan covers most of the medical expenses you and your family might incur, there are some expenses that are not covered.

Here is a list of some expenses that are not covered by the NYU Retiree Medical Plan:

- Expenses over and above the reasonable and customary charge, as determined by United HealthCare;
- Charges covered by a Workers' Compensation Act or similar legislation;
- Charges incurred during confinement in a hospital owned or operated by the government or any of its agencies, and charges for services, treatments, or supplies furnished by or for the United States government (including the U.S. armed forces) or any of its agencies;
- Charges for which there is no legal obligation to pay (for example, the amount of a discount on a product or service);
- Anything not ordered by a physician or not necessary for medical care;
- Charges for services or supplies that any school system is legally required to provide;
- Charges incurred for medical services, drugs, treatment, or supplies that are considered by United HealthCare to be experimental or still under investigation by health professionals;
- Charges for custodial care;
- Charges for any inpatient or private duty or special nursing services, regardless of whether rendered under the direction of the hospital or a physician;
- Charges for therapy, supplies, or counseling for sexual dysfunction;
- Charges for or related to eye surgery primarily to correct refractive errors;
- Charges for education, special education, or job training (including those services given in a facility that provides mental or psychiatric treatment);
- Charges for speech therapy to refine an individual's existing speech or to educate an individual whose speech has not yet developed;
- • Charges for plastic, reconstructive, or cosmetic surgery to improve, alter, or enhance appearance (including such surgery for psychological and emotional reasons), except under these conditions:
    - To improve the function of a part of the body that is malformed (but not the teeth or their supporting structure) as a result of a severe birth defect, including harelip and webbed fingers or toes; or a malformation as a direct result of disease or surgery to treat a disease or injury; or

- To repair an injury within two years of an accident, as long as the person is covered under the NYU Retiree Medical Plan at the time treatment is provided. This two-year period may be extended if there is a significant medical reason for the delay;
- Charges for or related to surgery for sex change, or treatment of gender identity disorders;

- Charges for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures;

- Charges for routine physical, vision, or hearing examinations, or immunizations or other preventive services and supplies;

- Charges for marriage, family, career, social adjustment, pastoral, or financial counseling;

- Charges for completing forms; or

- Charges for treatment that is not considered medically necessary by United HealthCare.

Eligibility for Medicare

Medicare is a health insurance program sponsored by the federal government and administered by the Health Care Financing Administration.

ELIGIBILITY FOR MEDICARE

You become eligible for Medicare at age 65. You are eligible before age 65 if you are totally disabled and have been receiving Social Security benefits for a period of two years or you have a chronic kidney disease requiring dialysis or a transplant.

ENROLLING FOR MEDICARE

If you are not receiving Social Security benefits, you must contact your local Social Security office to enroll for Medicare. It's best if you and/or your spouse enroll three months before reaching age 65. If there is no listing for the Social Security Administration in the white pages of your phone book, call 1-800-772-1213 to locate the nearest office. If you are already receiving Social Security benefits when you reach age 65 as described above, you will be enrolled automatically in Medicare Parts A and B. **Note: You must enroll for Medicare benefits when you first become eligible to do so. Once you are Medicare eligible, the NYU Retiree Medical Plan will pay benefits as the secondary plan even if you have not enrolled in Medicare. Please see the Coordination of Benefits section of this SPD for further information.**

EXPENSES COVERED BY MEDICARE

Medicare is divided into two parts—Part A for hospital benefits and Part B for other medical expenses.

Part A hospitalization coverage provides benefits for:

- Inpatient hospital care;
- Inpatient care in a skilled nursing facility after a hospital stay; and
- • Care in a home that is provided by an approved home health care agency.
- **Part B** coverage provides benefits for:
- Physicians' services;
- Outpatient physical therapy and speech pathology services; and
- A number of other medical services and supplies, including necessary home health services.

HOW THE MEDICARE AND THE NYU PLAN WORK TOGETHER

If you and/or your covered dependent is eligible for Medicare, Medicare pays its benefits first. The NYU Plan will determine its benefit as if the Medicare allowable amount is the reasonable and customary (R&C) charge. If you are eligible but have not enrolled for Medicare or refused its coverage, the NYU plan still bases its payment on what Medicare would have paid on your behalf.

The specific amount the plan pays depends on a number of factors:

- If your health care provider accepts Medicare assignment as total reimbursement;
- If expenses are covered by Medicare and/or the NYU plan; and
- If you've met the NYU and Medicare deductibles and out-of-pocket limit.

If you are eligible for Medicare and incur an expense that is not covered by Medicare but is covered by the NYU Retiree Medical Plan (for example, if you receive medical treatment while traveling in a foreign country), the plan will pay 80% of R&C covered charges.

Medicare assignment: This is a method of payment by which physicians and other health care providers agree to accept Medicare's approved charges as payment in full for covered services. The providers file the claim form and bill you only for the deductible and coinsurance amounts.

Medicare-participating providers must accept Medicare assignment. Non-participating physicians and other providers may or may not accept assignment. If the provider does not accept Medicare assignment, the provider by law may not charge more than Medicare's approved charge plus an allowance. Federal law places a limit on how much a physician can charge above Medicare‘s allowed charge. Medicare will still pay benefits first, after which the NYU plan pays up to 80% of the Medicare allowed charge. You are responsible for the remaining amount. Generally, your out-of-pocket costs will be greater when you use a non-participating provider.

The following pages show examples of how the NYU plan coordinates its payments with Medicare.

EXAMPLE ONE: A PHYSICIAN ACCEPTS MEDICARE ASSIGNMENT

When a physician accepts Medicare assignment as payment in full, the NYU Plan determines its payments based on the Medicare allowance rather than on the Medicare limiting charge. The difference between a provider’s regular charge and the Medicare allowance is a charge you are not legally obligated to pay. Therefore, the plan cannot consider charges for payment that are in excess of what Medicare considers an allowable charge. Here’s how the same claim as in example one above would be processed if the provider participates in Medicare (accepts assignment). (See Definitions for “Medicare allowance” and “Medicare limiting charge.”)

Claim: Physician‘s Regular Charge $285.00

Medicare Allowance $168.00

Amount Physician Accepts $168.00 (Same As Medicare Allowance)

NYU Reimbursement Amount $134.40 ($168.00 x 80%) (80% Of Medicare Allowance)

Minus Medicare Payable Amount For A Participating Physician -$134.40 ($168.00 x 80%)

Amount Payable From Nyu Plan $ 0.00 ($134.40 - $134.40)

Total Reimbursement Amount $134.40 From Medicare And NYU.

Your Out-Of-Pocket Cost $ 33.60 ($168.00 - $134.40) (20% Coinsurance Required By NYU Retiree Medical Plan

EXAMPLE TWO: A PHYSICIAN DOES NOT ACCEPT MEDICARE ASSIGNMENT

When a physician doesn't accept Medicare assignment, the plan pays benefits after Medicare, based on 80% of the Medicare limiting charge. This example assumes the Medicare and NYU plan deductibles have already been met.(See Definitions for "Medicare allowance"and "Medicare limiting charge.")

Claim: Physician's Regular Charge $285.00

Medicare Allowance $168.00

Medicare Limiting Charge* $193.20 [$168.00 + ($168.00 x 15%)] (Allowance Plus 15% Of Medicare Allowance)

NYU Reimbursement Amount $154.56 ($193.20 x 80%) (80% Of Medicare Limiting Charge*)

Minus Medicare Payable Amount For A Non-Participating -$134.40 ($168.00 x 80%) Physician Charge (80% Of Medicare Allowance)

Amount Payable From Nyu Plan $ 20.56 ($154.56 - $134.40)

Total Reimbursement Amount $154.56 From Medicare And NYU

Your Out-Of-Pocket Cost $ 38.64 ($193.20 - $154.56) (20% Coinsurance Required By NYU Retiree Medical Plan)

EXAMPLE THREE: YOU'VE REACHED THE OUT-OF-POCKET LIMIT

Let's assume that you have individual coverage and your combined deductible and coinsurance payments for the calendar year equal the out-of-pocket limit of $1,000. Because you've reached the out-of-pocket limit, the plan pays 100% of the Medicare allowance, reduced by any Medicare payments. This case assumes that your physician does participate in Medicare. (See Definitions for "Medicare Allowance".)

Claim: Physician's Regular Charge	$285.00
Medicare Allowance	$168.00
Amount Physician Accepts	$168.00
100% Of Medicare Allowance	$168.00
Minus Medicare Payable Amount For A Participating Physician	-$134.40 ($168.00 x 80%)
Amount Payable From NYU Plan	$33.60 ($168.00 - $134.40)
Your Total Reimbursement From Medicare And NYU	$168.00
Your Out-Of-Pocket Cost	$ 0.00

EXAMPLE FOUR: THE EXPENSE IS COVERED BY THE NYU PLAN AND NOT BY MEDICARE

You may find that Medicare doesn't cover an expense that is covered by the NYU plan--for example, if you need medical care while traveling abroad. When this happens, the expense is paid as though you are not eligible for Medicare, as seen in this example. This case assumes the deductible has been met.

Claim: Physician's Regular Charge $285.00

NYU Allowance For R&C Charge $285.00

Amount Payable From NYU Plan $228.00 ($285.00 x 80%) (80% Of R&C Charge)

Total Reimbursement Amount $228.00

Your Out-Of-Pocket Cost $57.00 (20% Coinsurance Required By Nyu Retiree Medical Plan)

EXAMPLE FIVE: YOU ENTER INTO A PRIVATE CONTRACT WITH YOUR PROVIDER

If you decide to receive services from a provider who has decided not to provide services through Medicare (which means the provider will not bill Medicare for any services provided to any Medicare beneficiary for two years), Medicare will not pay for any of these services. In this case, the NYU Retiree Medical Plan will not pay for services and you will have to pay the provider whatever is billed for the services provided.

Claim: Physician's Regular Charge	$ 285.00
Medicare Allowance	$ 0.00
Amount Payable from NYU Plan	$ 0.00
Your Out-of-Pocket Cost	$ 285.00

How to File a Medical Claim

To receive reimbursement for covered medical expenses, you'll need to complete a claim form and return it to United HealthCare. If you are eligible for Medicare, it's important that you submit your claims first to Medicare for payment.

IF YOU ARE NOT ELIGIBLE FOR MEDICARE

To file a claim you'll need to complete a Health Claim Transmittal form and return it, along with any itemized bills, to United HealthCare. Complete instructions for filing claims are included on your Health Claim Transmittal form. Forms are available on-line at www.nyu.edu/hr. Click on –Claim Form Managed Indemnity". Or you may request a form from the NYU Benefits Office.

The deadline for filing a claim is one year from the date the services were received.

IF YOU ARE ELIGIBLE FOR MEDICARE

Because Medicare provides your primary coverage and pays benefits first, you need to file your medical claims with Medicare before you can file a claim with the NYU plan.

If you are hospitalized, the hospital will automatically file the necessary claim forms with Medicare. If you receive other medical services or supplies that are covered by Medicare Part B, you or your physician must submit a claim to Medicare.

After you receive the Explanation of Benefits (EOB) from Medicare, you should then submit it along with any itemized bills and a completed Benefit Request Form to United Healthcare at:

P.O. Box 740800 Atlanta, GA 30374-0800

IF YOUR CLAIM IS DENIED

Claims which were denied by Medicare can be submitted to the NYU Retiree Medical plan for consideration.

MEDICARE CROSSOVER

Based on agreements with Medicare, we can receive an electronic copy of your Explanation of Medicare Benefits (EOMB) statement directly from the Medicare processor. Upon receipt of the EOMB, United Healthcare will process the balance of your claim under the provisions of the NYU Retiree Medical Plan. This eliminates the need for you and your physician to make a copy of the EOMB and submit a second claim to United Healthcare .

YOUR RIGHTS TO APPEAL A DENIED CLAIM

If you believe you are being denied any rights or benefits under the Plan, you may file a claim in writing with the Plan Administrator.

If any such claim is wholly or partially denied, the Plan Administrator will notify you of its decision in writing within 90 days of the date you filed your claim (or within 180 days, if special circumstances require an extension of time for processing the claim, and if written notice of such extension and circumstances is given to you within the initial 90 day period).

This notification will include the reasons for denial, the plan provisions on which the denial was based, and if needed, a request for further information. Also included will be additional information you may need if you choose to submit an appeal and an explanation of the claim procedure. If such notification is not given within such period, the claim will be considered denied as of the last day of such period and such person may request a review of his or her claim.

If you or your beneficiary wish to contest the denial, you (or your legal representative) may request a review of the decision in writing within 60 days of the date you received the denial. Your appeal should include a description of the benefits you‘re claiming and the reasons for your claim. Also, supporting documents and records should accompany your appeal. You should send your appeal to the Plan Administrator.

The Plan Administrator will notify you of its decision in writing within 60 days after your request for review is received by the Plan Administrator (or within 120 days, if special circumstances require an extension of time for processing the request, such as an election by the Plan Administrator to hold a hearing, and if written notice of such extension and circumstances is given to you within the initial 60 day period). If the decision on review is not made within such period, the claim will be considered denied. Any action or decision made in the appeal process is final.

How the Plan Coordinates With Other Plans

The NYU Retiree medical Plan coordinates with other group plans covering you and/or your dependents. Benefits payable from Medicare are considered before the NYU Plan pays benefits, whether or not you have elected Medicare when eligible.

COORDINATION OF BENEFITS

If an expense is covered by both your NYU Retiree Medical Plan and another group health benefits plan, one will be the primary plan and have first responsibility for payment. If your NYU Retiree Medical Plan is the primary plan, it will pay benefits as if it were the only plan. If your NYU plan is the secondary plan, the benefits from the other plans will be taken into account when your NYU plan benefits are determined. This provision, known as ~~"c~~oordination of benefits," may mean a reduction in payments from this plan. The combined benefits will not be more than 100% of the expenses recognized under both plans. If this plan is not the primary plan, the NYU Plan first determines the amount it would pay in the absence of another plan. If this is more than the amount payable from the primary plan, the NYU Plan will pay the difference.

When the primary plan has paid its benefits, the secondary plan may pay an additional amount based on its provisions. The following guidelines determine which plan pays first:

- If you or a covered dependent is eligible for Medicare benefits -- even if you have not applied for them -- Medicare is primary.

- If the expense is for a covered dependent under the NYU Retiree Medical Plan who is covered as an employee (not as a dependent) under another plan, the other plan is primary.

- If the plan covers you as a retiree, it pays benefits before a plan that covers you as a dependent of a retiree.

- If the plan covers you as a retiree, it pays benefits after a plan that covers you as a dependent of an active employee.

- If the expense is for a dependent child covered under both parents' plans, the primary plan is the plan of the parent whose birthday falls earlier in the calendar year. For example, if the father's birthday is in May and the mother's birthday is in September, the father's plan would be primary for the dependent child. However, if the other plan does not use this "birthday" rule, that plan's coordination of benefits provisions will determine which plan is primary.
- • If you are separated or divorced and if the court has declared one parent as financially responsible for the covered dependent child's health care benefits, the plan of the parent with that responsibility is primary. Otherwise, benefits are paid in this order:
    - The plan of the parent with custody of the child; or
    - The plan of the stepparent married to the parent with custody of the child; or
    - The plan of the parent who does not have custody of the child.

• • When the other plan does not use a coordination of benefits program, that plan pays first. Other plans that provide medical benefits include the following:

• Group insurance;

• Any other type of coverage for persons in a group, including insured and uninsured plans; and

• No-fault auto insurance required by law and not provided on a group basis. Only the level of benefits required by the law will be counted.

• Coordination of benefits does not apply to any individual health insurance policy you may have purchased.

MEDICARE COORDINATION

If you are eligible for Medicare benefits, the NYU plan first determines the amount it will pay as if the Medicare allowable amount is the reasonable and customary (R&C) charge. If this is more than the amount payable from Medicare for the expenses involved, the NYU plan will pay the difference. In other words, benefits you receive from Medicare directly reduce the payments from the NYU plan so that your total reimbursement is equal to what you would have received as an active employee. (See examples of payments on pages 30 and 31.)

Coordination with Medicare benefits will apply as soon as you and/or your covered dependent are eligible for Medicare -- even if you have refused, discontinued, or neglected to apply for Medicare coverage.

When Coverage Ends

RETIREE COVERAGE

Coverage under the NYU Retiree Medical Plan ends on the earliest of:

- When you are no longer in the eligible class of retired employees described on page 4 (this may apply to all or part of your coverage);
- When you fail to make any required contribution;
- When you die; or
- When the group policy for retiree coverage terminates.

If your coverage ends, you or your covered dependents should contact the NYU Benefits Office immediately to find out if you or your covered dependents are eligible for continuation coverage or conversion privileges. For more information, see page 38.

If you die while you have plan coverage, your covered dependents (surviving spouse or registered same-sex domestic partner and eligible children) automatically remain covered by the plan until they lose eligibility for coverage under the plan. Please refer to "When Coverage Ends" for further information

COVERAGE CERTIFICATION

Based on provisions of the Health Insurance Portability and Accountability Act, which are effective June 1, 1997, if you choose to end coverage under the NYU Retiree Medical Plan after this date – for example, if your spouse is employed and you enroll for coverage as a dependent under your spouse's medical plan – you'll receive a certificate confirming your period of coverage under the NYU Plan. This certificate will be provided:

- If you end your coverage under the NYU Retiree Medical Plan;
- When your coverage under COBRA ends (if you are eligible for COBRA continuation; see page 38); or
- Upon request, within 24 months after coverage under the plan ends.

DEPENDENT COVERAGE

A dependent's coverage ends when the first of the following occurs:

- A dependent becomes covered as an NYU employee;
- A dependent fails to meet the eligibility requirements;
- You fail to make required contributions for dependent coverage;
- Your coverage ends, except when due to your death;
- You elect not to continue to cover that dependent; or
- All coverage for dependents under the group policy is terminated.

Continuation for Handicapped Children

Medical coverage for your fully handicapped, unmarried child may be continued past the maximum age for an eligible dependent child, if the child has not been issued an individual medical conversion policy.

Your child is fully handicapped if:

- The child is not able to earn his or her own living because of mental illness, developmental disability, mental retardation (as defined in the mental hygiene law), or a physical handicap that started before the date the child reaches the maximum age for eligible dependent children; and

- The child depends chiefly on you for support and maintenance.

- United HealthCare will have the right to require proof of the continuation of the handicap. United HealthCare also has the right to have a physician examine your child, at its own expense, as often as reasonably needed while the handicap continues.

Proof that your child is fully handicapped must be submitted to United HealthCare no later than 31 days after the date your child reaches age 19.

Continued coverage for handicapped children will end on the earliest to occur of:

- Cessation of the handicap;

- Failure to give proof that the handicap continues;

- Failure to have any required exam; or

- Termination of your dependent child's coverage for any reason other than reaching the maximum age, such as marriage, failure to pay required contributions, termination of the plan, etc.

Coverage Continuation Options

If coverage terminates for you and/or your covered dependents, certain continuation provisions may be available under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or a conversion option.

COBRA CONTINUATION

This continuation coverage option is available to your covered dependents when a change in eligibility status -- due to a qualifying event -- would otherwise disqualify them from participation in the plan. Covered dependents are required to pay 102% of the full cost for continued group coverage.

COBRA continuation coverage is available to your covered dependents who are not eligible for Medicare for up to 36 months when their NYU Retiree Medical Plan coverage ends because of one of the following qualifying events:

- Your divorce or legal separation; or
- The date your child is no longer considered an eligible dependent.

If a second qualifying event occurs during continuation coverage, your covered dependent is eligible to continue coverage for no more than 36 months from the date of the first qualifying event.

Continuation coverage ends if your covered dependent:

- Becomes covered under another group health plan (that does not have a preexisting condition limitation);
- Fails to pay the required premiums within 30 days of the date payments are due (except for the first premium which is due 45 days after COBRA is elected);
- Reaches the end of the continuation coverage period; or
- Becomes entitled to Medicare benefits.

Continuation coverage also ends if NYU terminates the Retiree Medical Plan.

HOW TO APPLY

If your covered dependent expects to lose dependent coverage (in the case of a divorce, legal separation, or a child reaching the age at which coverage ends), you or your covered dependent must notify the NYU Benefits Office within 60 days of the qualifying event or the date coverage is scheduled to end, if later. Your eligible dependents will be sent an election notice of the cost and the right to continue coverage under the NYU Retiree Medical Plan.

Your dependents have 60 days following the date of the notice (or the date plan coverage ends, whichever is later) to elect to continue coverage. The period of continuation coverage is counted from the date of the original qualifying event.

PAYING FOR COVERAGE

For medical coverage to continue, your covered dependents must pay the full cost of coverage and make the initial payment within 45 days of the date they elect to continue coverage. Your covered dependent must continue to pay the cost of coverage within 30 days of the date payments are due. If payment is not made within 30 days, coverage ends automatically.

In most cases, continuation coverage and its cost will not change more often than once a year. If, however, NYU changes coverage for retired employees, continuation coverage will change accordingly.

CONVERTING TO AN INDIVIDUAL POLICY

You and/or your covered dependents may convert their NYU Retiree Medical Plan coverage to an individual medical policy if an event occurs that results in the loss of coverage. You and/or your covered family members may convert to an individual policy when:

- You are no longer eligible for coverage and are not eligible for Medicare;
- Your dependents want to continue coverage beyond the period of COBRA continuation; or
- Your dependents are eligible for COBRA coverage and want to convert to an individual policy instead.

No one can convert to an individual policy if coverage ends because the NYU Retiree Medical Plan group policy is discontinued.

The individual policy may cover:

- Yourself only;
- You and all of your family members who are covered under this plan when your coverage ends; or
- All of your family members who are covered under the NYU Retiree Medical Plan when your coverage ends because of your death.

The individual policy must be applied for within 45 days after NYU group coverage ends. The 45-day period starts on the date coverage for you or your covered dependents ends. This application period will be extended for 45 days from the date NYU gives written notice of this conversion privilege, as required by law, but not beyond 90 days from the date coverage ends. This applies even if you or your covered dependent is still eligible for benefits because of a total disability.

The first premium for the individual policy must be paid at the same time your dependent applies for a policy. The premium will be United HealthCare's premium charge for the person's class and age, and the form and amount of coverage.

The individual policy will take effect on the day after coverage terminates under the NYU Retiree Medical Plan.

United HealthCare may decline to issue the individual policy if:

- It is applied for in a jurisdiction in which United HealthCare cannot issue or deliver the policy; or
- • On the date of conversion, a person is covered, eligible, or has benefits available under one of the following, which with the converted policy, would result in overinsurance or would match benefits:
  - Any other hospital or surgical expense insurance policy;
  - Any hospital service or medical expense indemnity corporation subscriber contract;
  - Any other group contract; or
  - Any statute, welfare plan, or program.

Conversion is not available to you or a covered dependent who has been insured under this plan for less than three months or who becomes eligible for Medicare. Also, conversion is not available if:

- You or your covered dependent has exhausted the maximum benefit; or

- You or your covered dependent becomes eligible for any other medical expense coverage through NYU.

This individual policy's form and its terms will be of a type offered by United HealthCare under the NYU Conversion Plan for group insurance conversions at the time you apply for the policy.

It will have benefits at least in line with any law or regulation that applies. United HealthCare or NYU will give you details on request.

Coverage may be elected under a major medical expense benefits plan which provides:

- A $180 per day hospital room and board benefit;
- Surgical expense benefits according to a $2,500 maximum benefits schedule;
- A $100,000 maximum benefit for all sicknesses and injuries; and
- An 80% benefit percentage, with a coinsurance limit of $2,000. The individual policy may contain either or both of:
- A statement that benefits will be cut back by any similar benefits payable under the NYU Retiree Medical Plan after your coverage ends; and/or
- A statement that United HealthCare may on any premium due date of the individual policy ask for data about your coverage under any other plan. If you do not provide the data, expenses covered under the individual policy may be reduced by expenses that are covered or provided under those plans.

The individual policy will state that United HealthCare has the right to refuse renewal under the conditions outlined in the policy.

To convert coverage to an individual policy:

- Ask the NYU Benefits Office for a copy of the Notice of Conversion Privilege and Request form; and
- Send the completed form to the address shown on the form.

United HealthCare will send you or your covered dependent, if eligible, information about the individual policy directly.

Situations Affecting Plan Benefits

ASSIGNMENT

All coverage may be assigned only with the consent of United HealthCare.

PAYMENT OF BENEFITS

Benefits will be paid as soon as the necessary written proof to support the claim is received.

All benefits are payable to you. However, United HealthCare has the right to pay any medical benefits to the service provider. This will be done unless you have told United HealthCare otherwise by the time you file the claim.

United HealthCare may pay up to $1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

KEEPING RECORD OF EXPENSES

Keep complete records of the expenses of each person. They will be required when you file a claim.

It is important that you include the following information on your claim:

- Names of physicians, dentists, and others who furnish services;
- Date expenses are incurred; and
- Copies of all bills and receipts.

PHYSICAL EXAMINATIONS

United HealthCare will have the right and opportunity to examine any person who is the basis of any claim at all reasonable times while that claim is pending. This will be done at United HealthCare‘s expense.

LEGAL ACTION

No legal action can be brought to recover under any benefit after one year from the deadline for filing claims.

GENERAL

The following additional provisions apply to your coverage:

- You cannot receive multiple coverage under this plan or any other plan offered by NYU.

- In the event of a misstatement of any fact affecting your coverage under this plan, the true facts will be used to determine the coverage in force.

This booklet describes the main features of the NYU Retiree Medical Plan. Additional provisions are described elsewhere in the plan documents. If there is any conflict between this booklet and the documents, the documents will govern.

If you have any questions about the terms of the Plan or about the proper payment of benefits, you may obtain more information from the NYU Benefits Office or from United HealthCare.

NYU hopes to continue the plan indefinitely but, as with all group plans, the plan may be changed or discontinued at any time with respect to all or any class of employees. NYU provides the retiree medical plan for your benefit; however, you do not have a vested right to benefits or to a minimum level of coverage.

Some Important Definitions

These definitions may be helpful as you read about the NYU Retiree Medical Plan.

Birthing Center A freestanding facility which meets fully every one of the following tests:

- Meets licensing standards;
- Is set up, equipped and run to provide prenatal care, delivery, and immediate postpartum care;
- Makes charges;
- Is directed by at least one physician who is a specialist in obstetrics and gynecology;
- Has a physician or certified nurse midwife present at all births and during the immediate postpartum period;
- Extends staff privileges to physicians who practice obstetrics and gynecology in an area hospital;
- Has at least two beds or two birthing rooms for use by patients while in labor and during delivery;
- Provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a registered nurse (R.N.) or certified nurse midwife;
- Provides or arranges with a facility in the area for diagnostic X-ray and laboratory services for the mother and child;
- Has the capacity to administer a local anesthetic and to perform minor surgery (this includes episiotomy and repair of perineal tear);
- • Is equipped and has trained staff to handle medical emergencies and provide immediate support measures to sustain life:
    - If complications arise during labor; and
    - If a child is born with an abnormality which impairs function or threatens life;
- Accepts only patients with low risk pregnancies;
- Has a written agreement with a hospital in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them;
- Provides an ongoing quality assurance program. This includes reviews by physicians who do not own or direct the facility; and
- • Keeps a medical record on each patient and child.

- **Convalescent Facility** An institution (or distinct part thereof) which meets fully every one of the following tests:

- It is licensed to provide and is engaged in providing, on an inpatient basis, for persons convalescing from injury or disease, professional nursing services rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of

an R.N. and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities;

- Its services are provided for compensation from its patients and under the full-time supervision of a physician or R.N.;
- It provides 24-hour-per-day nursing services by licensed nurses, under the direction of a full-time R.N.;
- It maintains a complete medical record on each patient;
- It has an effective utilization review plan; and
- It is not, other than incidentally, a place for the aged, substance abusers, the mentally retarded; or for rest, custodial or educational care, or care of mental disorders.

Custodial Care Coverage is not provided for custodial care. Custodial care means care comprised of services and supplies, including room and board and other institutional services, which are provided to an individual, whether disabled or not, primarily to assist the individual in the activities of daily living. Such services and supplies are custodial care without regard to the practitioner or provider by whom or by which they are prescribed, recommended,or performed.

Effective Treatment Of Alcoholism Or Drug Abuse Treatment of alcoholism or drug abuse in accordance with a treatment plan submitted to United HealthCare by a physician, hospital or treatment facility. The treatment plan must be approved by United HealthCare.

Treatment solely for detoxification or primarily for maintenance care is not considered effective treatment. Detoxification is care aimed primarily at overcoming the after effects of a specific episode of drinking or drug abuse. Maintenance care consists of the providing of an environment without access to alcohol or drugs.

Home Health Care Agency (New York Residents) A hospital or a non-profit or public home health care service or agency operating under a valid New York Public Health Law certificate which allows the institution to provide the home health care services involved.

Home Health Care Agency (Non-New York Residents) Any agency or organization which meets fully every one of the following requirements:

- It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services;
- It has policies established by a professional group associated with the agency or organization. This professional group must include at least one physician and at least one registered nurse (R.N.) to govern the services provided, and it must provide for full-time supervision of such services by a physician or R.N.;
- It maintains a complete medical record on each individual; and
- It has a full-time administrator.

Home Health Care Plan A program for care and treatment of the individual established and approved in writing by the individual's attending physician. The attending physician must certify that the proper treatment of the disease or injury would require confinement as a resident inpatient in a hospital or a skilled nursing facility as defined in Title XVIII of the Social Security Act in the absence of the services and supplies provided as part of the home health care plan.

Hospice Care Care given to a terminally ill person by or under arrangements with a hospice care agency. The care must be part of a hospice care program.

Hospice Care Program A written plan of hospice care which:

- Is established by and reviewed from time to time by:
  - A physician attending the person; and
  - Appropriate personnel of a hospice care agency.
- • Is designed to provide:
  - Palliative and supportive care to terminally ill persons; and
  - Supportive care to their families.
- • Includes:
  - An assessment of the person's medical and social needs; and
  - A description of the care to be given to meet those needs.

Hospice Facility A facility, or distinct part of one, which:

- Mainly provides inpatient hospice care to terminally ill persons;
- Charges its patients;
- Meets any licensing or certification standards set forth by the jurisdiction where it is located;
- • Provides:
  - Skilled nursing services,
  - Medical social services,
  - Psychological and dietary counseling, and
  - Bereavement counseling for the immediate family;
- • Provides or arranges for other services which will include:
  - Services of a physician,
  - Physical or occupational therapy,
  - Part-time home health aide services which mainly consist of caring for terminally ill persons, and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management;
- • Has personnel which includes at least:
  - One physician,
  - One R.N.,
  - One licensed or certified social worker employed by the agency, or
  - One pastoral or other counselor;
- Establishes policies governing the provision of hospice care;
- Assess the patient's medical and social needs;
- Develops a hospice care program to meet assessed medical and social needs;
- Provides an ongoing quality assurance program. This includes reviews by physicians other than those who own or direct the agency;
- Permits all area medical personnel to utilize its services for their patients;
- Keeps a medical record on each patient;

- Utilizes volunteers trained in providing services for non-medical needs;
- • Has a full-time administrator.

- **Hospital** An institution which fully meets every one of the following tests:

- It is primarily engaged in providing, for compensation and on an inpatient basis, facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons under the supervision of a staff of physicians;

- It continuously provides 24-hour registered nurse (R.N.) service; and

- It is not, other than incidentally, a place for rest, for the aged, for substance abusers, or a nursing home.

Injury A medical condition resulting from an event which is unforeseen and indefinite as to time and place.

Legally Qualified Dentist Any coverage provided for charges by a dentist will be available only if the charges are made by a legally qualified dentist or a physician authorized by license to perform the particular dental procedure rendered at the time and place involved.

Legally Qualified Physician Any coverage provided for charges by a physician will be available only if the charges are made by a legally qualified physician.

Medicare Allowance When Medicare assignment is accepted by a physician, he or she agrees to the Medicare-approved charge – or the Medicare allowance – as the full charge and bills the patient only the 20% coinsurance amount not paid by Medicare.

Medicare Limiting Charge The Medicare limiting charge places restrictions on how much non-participating physicians, suppliers, or other persons are allowed to charge a Medicare patient if the provider of services does not accept the assignment. The limiting charge is 115% of the Medicare-approved charge.

Medically Necessary Coverage is provided only for a service or supply which is medically necessary for the diagnosis, care, or treatment of the physical or mental condition involved. It must be widely accepted professionally in the United States as effective, appropriate, and essential based upon recognized standards of the health care specialty involved.

In no event will the following be considered medically necessary:

- Those services rendered by a provider that do not require the technical skills of such provider;
- Those services and supplies furnished mainly for the personal comfort or convenience of the patient, any individual who cares for the patient, or any individual who is part of the patient's family;
- Those services and supplies furnished to an individual solely because the individual is an inpatient on any day on which the individual's physical or mental condition could safely and adequately be diagnosed or treated while not confined; or
- That part of the cost which exceeds that of any other service or supply that would have been sufficient to safely and adequately diagnose or treat the individual's physical or mental condition.

Orthodontic Treatment Any medical or dental service or supply furnished to prevent, diagnose, or correct a misalignment of the teeth, bite, jaws, or jaw joint relationships, whether or not for the purpose of relieving pain. It does not include the installation of a space maintainer or a surgical procedure to correct malocclusion.

Reasonable And Customary (R&C) Charges Only that part of a charge which is R&C is covered. Except as provided below, the R&C charge for a service or supply is the lower of the provider's usual charge for furnishing it and the charge United HealthCare determines to be the prevailing charge made for it in the geographic area where it is furnished.

In determining the R&C charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of providers in the area. United HealthCare may take into account factors, such as:

- The complexity of the procedure;
- The degree of skill needed;
- The type of specialty of the provider;
- The range of services or supplies provided by a facility; or
- The prevailing charge in other areas.

Room And Board Charges The institution's charges for room and board and its charges for other necessary institutional services and supplies made as a condition of occupancy of the type of accommodations occupied.

Semiprivate Rate The room and board charge which an institution applies to the greatest number of beds in its semiprivate rooms containing two or more beds. If the institution has no semiprivate rooms, the semiprivate rate will be the room and board rate most commonly charged for semiprivate rooms with two or more beds by similar institutions in the area. The term area means a city, a county, or any greater area necessary to obtain a representative cross section of similar institutions.

Terminally Ill A medical prognosis of six months or less to live.

Treatment Facility An institution (or distinct part thereof) which fully meets every one of the following tests:

• If the facility is located in the State of New York:

- It is primarily engaged in providing, for compensation from its patients, a program for diagnosis, evaluation, and effective treatment of alcoholism or drug abuse; and
- It meets any applicable licensing standards established by the State of New York;

• • If the facility is located in any other jurisdiction:

- It is primarily engaged in providing, for compensation from its patients, a program for diagnosis, evaluation, and effective treatment of alcoholism or drug abuse;
- It provides all medical detoxification services on the premises, 24 hours a day;
- It provides all normal infirmary-level medical services required during the treatment period, whether or not related to the alcoholism or drug abuse. Also, it provides, or has an agreement with a hospital in the area to provide, any other medical services that may be required;
- At all times during the treatment period, it is under the supervision of a staff of physicians and provides skilled nursing services by licensed nursing personnel under the direction of a full-time registered nurse;
- It prepares and maintains a written individual plan of treatment for each patient based on a diagnostic assessment of the patient's medical, psychological, and social needs;
- It meets any applicable licensing standards established by the jurisdiction in which it is located.

Treatment Of Mental Or Nervous Disorders Or Conditions Treatment of a mental or nervous disorder or condition not related to, accompanying, or resulting from the individual's alcoholism or drug abuse. The treatment of any such related, accompanying, or resulting disorder or condition will be considered to be treatment of the alcoholism or drug abuse.

Claim Procedures

Claim forms may be obtained on-line at www.nyu.edu/hr or at the NYU Benefits Office. These forms tell you how and when to file a claim.

Claims must be filed within one year of the date the charges are incurred. If your claim is denied in whole or in part, you will receive a written notice of the denial from United HealthCare. The notice will explain the reason for the denial and the review procedures.

You may request a review of the denied claim. The request must be submitted in writing within 60 days after you receive the notice. Include your reasons for requesting the review. Submit your request to:

United HealthCare
P.O. Box 740800 Atlanta,
GA 30374-0800

United HealthCare will review your claim and ordinarily notify you of its final decision within 60 days of receipt of your request. If special circumstances require an extension of time, you will be notified of such extension during the 60 days following receipt of your request.

If your claim is denied you have a right to appeal the denial. See "Your Rights to Appeal A Denied Claim."

ERISA Information

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). Your Plan Administrator has determined that the following information, together with the information contained in this booklet, is the Summary Plan Description required by ERISA.

PLAN NAME
New York University Medical Expense Plan for Retirees

Employer Identification Number
13-5562308

Plan Number - 520

Type Of Plan -Medical

Organizations Providing Administrative Services
Medical
Administrative Services Only United HealthCare
P. O. Box 740800 Atlanta, GA 30374-0800 1-800-214-1736

Presciption Drug Mail-Order program
Caremark, Inc.
P.O. Box 407009 Fort Lauderdale, FL 33340-7009 1-800-344-8075

Prescription Drug Retail Program
Caremark, Inc.
P.O. Box 686005 San Antonio, TX 78268-6005 1-800-421-5501

Plan Year
January 1 - December 31
Plan Administrator And Sponsor
The administration of the Plan shall be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator shall have the discretion to determine all matters relating to eligibility, coverage and benefits under the Plan, and the Plan Administrator shall have the discretion to determine all matters relating to the interpretation and operation of the Plan. Any determination by the Plan Administrator, or any authorized delegate, shall be final and binding, in the absence of clear and convincing evidence that the Plan Administrator or delegate acted arbitrarily and capriciously.

New York University Benefits Office 105 E. 17th St., 1st floor New York, NY 10003
Telephone (212) 998-1270 or E-mail: benefits@nyu.edu

Agent For Service Of Legal Process
If, for any reason, you wish to seek legal action, you may serve legal process on the Plan

Sponsor, the Plan Administrator or to the Agent for Service of Legal Process at the following address:

New York University Office of Legal Counsel Elmer Holmes Bobst Library 70 Washington Square South, 11th floor New York, NY 10012

Amendment And Termination Of The Plan

The Plan Sponsor has established the plan with the bona fide intention and expectation that it will be continued indefinitely, but the Plan Sponsor shall not have any obligation whatsoever to maintain the plan for any given length of time, and the Plan Sponsor may at any time amend or terminate the plan, in whole or in part, with respect to any or all of its participants and/or beneficiaries. Any such amendment or termination shall be effected by a written instrument signed by an officer of the Plan Sponsor, or his or her authorized delegate. No vested rights of any nature are provided under the plan.

As a participant in the NYU Medical Expense Plan for Retirees (Plan number 520) you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

ERISA, provides that all plan participants shall be entitled to:

- 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 in the Public Disclosure Room of the Pension and Welfare benefit 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 summary plan description. The Plan 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.

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 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 administrator. If you have a claim for benefits which 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.