Fordham University Benefit Summary
Choice Plus Medical Plan: HSA Option

This summary was prepared to help you understand the benefits available through your Choice Plus Medical Plan coverage: HSA Option. If you want more details about your coverage and costs, you can get the complete terms in the plan documents. Your contact for plan information is the University’s Benefits Office at (718) 817-4932 or benefits@fordham.edu.

The HSA Option offers the flexibility of receiving care from in-network and out-of-network health care providers. Your share of the cost is always lower when you receive care from a provider in the UnitedHealthcare Choice Plus network. However, you have the option to go outside the network and pay more. You do not need referrals to see a specialist.

The HSA Option covers in-network preventive care expenses in full. Other expenses are subject to an annual deductible. Once you meet the deductible, expenses are generally paid at 80% in-network or 60% if you go out-of-network for care. Your share—20% in-network or 40% out-of-network—is your coinsurance. Out-of-network services for emergency care are paid as in-network expenses. Once you meet your deductible, copays apply to prescription drug expenses.

Benefits for out-of-network medical care are based on the plan’s usual, customary, and reasonable (UCR) charge for each service. If a physician or other medical provider charges more than the UCR, you may be billed for the excess amount, along with your coinsurance percentage. UCR is based on information from the FAIR Health Database, which surveys doctors every six months on their fees. The UCR for the HSA Option is set at 70% of the range for the applicable geographic area where the service is being rendered.

To protect you from catastrophic expenses, the plan limits the amount you pay out-of-pocket in a calendar year. The out-of-pocket maximum includes deductibles, copays, and coinsurance. Separate out-of-pocket maximums apply to in-network and out-of-network expenses.

This summary describes key plan features. A chart with common medical events shows how these plan features apply when you have health care expenses.

<table>
<thead>
<tr>
<th>Plan feature</th>
<th>What it is</th>
<th>How it affects your plan benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider network</td>
<td>The plan pays the highest level of benefits when you use providers in the Choice Plus network. Reduced benefits are available if you go outside the network for care</td>
<td>In-network, most benefits are paid at 80% after you meet an annual deductible. There are no claim forms to file.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-of-network, you pay a higher deductible and coinsurance. You may need to pay the expense up front and file a claim for reimbursement.</td>
</tr>
<tr>
<td>Health Savings Account</td>
<td>A tax-free account you may use to pay current or future out-of-pocket health care expenses. The University contributes to your account, and you may add your own tax-free contributions</td>
<td>The account is available only if you choose the HSA Option. You may use your HSA to pay in-network and out-of-network expenses.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
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<th>Plan feature</th>
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<tr>
<td><strong>Annual deductible</strong></td>
<td>An amount you pay each year before the plan begins to pay benefits. If you cover your family, no one in the family is eligible for benefits until the family coverage deductible is met</td>
<td>$1,500 employee only&lt;br&gt;$3,000 family&lt;br&gt;$3,000 employee only&lt;br&gt;$6,000 family</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>The percentage of costs you and the plan each pay, after you meet the deductible</td>
<td>After you meet the deductible, the plan pays 80% of the cost of care; you pay 20%&lt;br&gt;After you meet the deductible, the plan pays 60% of the cost of care; you pay 40%</td>
</tr>
<tr>
<td><strong>Copay</strong></td>
<td>An amount you pay toward the cost of prescription drug expenses after you meet your deductible</td>
<td>Prescription copay amounts vary depending on type of drug and whether the purchase is retail or mail order</td>
</tr>
<tr>
<td><strong>Out-of-pocket maximum</strong></td>
<td>An annual limit on the amount you spend for covered health care expenses; includes deductibles, coinsurance, and copays. The plan pays 100% of additional covered expenses for the year if you reach your out-of-pocket maximum</td>
<td>$3,000 employee only&lt;br&gt;$6,000 family&lt;br&gt;$6,000 employee only&lt;br&gt;$12,000 family</td>
</tr>
<tr>
<td><strong>Preventive care</strong></td>
<td>Preventive care is covered in full in-network. Coverage includes annual check-ups, lab tests, and screenings based on age and gender</td>
<td>Plan pays 100%&lt;br&gt;Plan pays 60%, you pay 40% after the deductible</td>
</tr>
</tbody>
</table>
The chart that follows shows how you and the plan share costs, depending on the type of health care services you need and where those services are delivered. Your covered dependents are eligible for the same benefits described below.

<table>
<thead>
<tr>
<th>Common medical events</th>
<th>Services you may need</th>
<th>If you stay in-network</th>
<th>If you go out-of-network</th>
<th>Limitations and exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>You get a routine physical exam</td>
<td>• Physician’s office visit</td>
<td>No cost to you; plan pays 100%</td>
<td>You pay 40% after the deductible; plan pays 60%</td>
<td>The schedule of covered services for preventive care is based on health care reform guidelines for adults and children. Gender-specific tests and screenings apply as well. Learn more at <a href="https://www.healthcare.gov/what-are-my-preventive-care-benefits/">https://www.healthcare.gov/what-are-my-preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td></td>
<td>• Lab work, imaging, and other preventive tests and screenings based on your age and gender (e.g., blood pressure and cholesterol screenings, immunizations, mammogram, prostate exam, colonoscopy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You need to see a doctor because of an illness or injury</td>
<td>• Primary care, specialist, and urgent care center visits</td>
<td>You pay 20% after the deductible; plan pays 80%</td>
<td>You pay 40% after the deductible; plan pays 60%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Outpatient diagnostic lab and x-ray tests; scopic* procedures; CT, PET, and MRI imaging; surgery; therapeutic treatments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You require emergency room care</td>
<td>• Ambulance transportation</td>
<td>You pay 20% after the deductible; plan pays 80%</td>
<td></td>
<td>In- and out-of-network, pre-service notification required for non-emergency ambulance transportation Out-of-network, pre-service notification is required if ER visit results in inpatient stay</td>
</tr>
<tr>
<td></td>
<td>• Evaluation by hospital ER staff; related fees for diagnostic tests and treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You are admitted to the hospital</td>
<td>• Daily hospital room and board charges, services, and supplies</td>
<td>You pay 20% after the deductible; plan pays 80%</td>
<td>You pay 40% after the deductible; plan pays 60%</td>
<td>Out-of-network, pre-service notification is required</td>
</tr>
<tr>
<td></td>
<td>• Physician and hospital staff charges</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Diagnostic lab and x-ray tests; scopic* procedures; CT, PET, and MRI scans; anesthesia; surgery; pharmaceutical and therapeutic treatments</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Scopic procedures are those required for visualization, biopsy, and polyp removal, and include endoscopy, colonoscopy, and sigmoidoscopy.*
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</thead>
<tbody>
<tr>
<td>You have outpatient surgery</td>
<td>• Physicians’ charges&lt;br&gt;• Facility fees</td>
<td>You pay 20%, after the deductible; plan pays 80%</td>
<td>You pay 40% after the deductible; plan pays 60%</td>
<td></td>
</tr>
<tr>
<td>You need hearing aids</td>
<td>• Hearing exam, with services as needed by ear, nose, and throat specialist&lt;br&gt;• Hearing aid</td>
<td>You pay 20% after the deductible; plan pays 80%</td>
<td>You pay 40% after the deductible; plan pays 60%</td>
<td>Covers a single purchase (including repair/replacement) per hearing impaired ear once every three years</td>
</tr>
<tr>
<td>You are pregnant</td>
<td>• Physician’s office visits&lt;br&gt;• Screenings and lab work prescribed by your doctor&lt;br&gt;• Hospital charges for labor, delivery, and newborn care</td>
<td>You pay 20% after the deductible; plan pays 80%</td>
<td>You pay 40% after the deductible; plan pays 60%</td>
<td></td>
</tr>
<tr>
<td>You undergo infertility treatment</td>
<td>• New York state-mandated benefits, including testing, and high-level counseling&lt;br&gt;• Services for the diagnosis and treatment of corrective medical conditions which result in fertility</td>
<td>You pay 20% after the deductible; plan pays 80%</td>
<td>You pay 40% after the deductible; plan pays 60%</td>
<td>Pre-service notification is required in- and out-of-network</td>
</tr>
<tr>
<td>You require mental health or substance abuse treatment</td>
<td>• Outpatient care&lt;br&gt;• Inpatient care</td>
<td>You pay 20% after the deductible; plan pays 80%</td>
<td>You pay 40% after the deductible; plan pays 60%</td>
<td>Pre-service notification is required out-of-network</td>
</tr>
<tr>
<td>You require rehabilitative services (e.g., physical, occupational, or speech therapy; chiropractic care; pulmonary or cardiac therapy; cognitive or vision therapy)</td>
<td>• Outpatient care</td>
<td>You pay 20% after the deductible; plan pays 80%</td>
<td>You pay 40% after the deductible; plan pays 60%</td>
<td>Benefits are limited to 60 visits a year for each type of rehabilitative service&lt;br&gt;Pre-service notification is required for chiropractic care</td>
</tr>
</tbody>
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</tr>
</thead>
<tbody>
<tr>
<td>You need special treatment, equipment, or care in an alternative medical setting</td>
<td>• Treatments such as dialysis, IV chemotherapy or other IV infusion therapy, radiation oncology</td>
<td>You pay 20% after the deductible; plan pays 80%</td>
<td>You pay 40% after the deductible; plan pays 60%</td>
<td>Pre-service notification is required for dialysis out-of-network</td>
</tr>
<tr>
<td></td>
<td>• Durable medical equipment</td>
<td>You pay 20% after the deductible; plan pays 80%</td>
<td>You pay 40% after the deductible; plan pays 60%</td>
<td>Once every three years per single purchase Pre-service notification is required for equipment that costs more than $1,000 for out-of-network</td>
</tr>
<tr>
<td></td>
<td>• Skilled nursing care</td>
<td>You pay 20% after the deductible; plan pays 80%</td>
<td>You pay 40% after the deductible; plan pays 60%</td>
<td>Benefits are limited to 60 days a year Pre-service notification is required for out-of-network</td>
</tr>
<tr>
<td></td>
<td>• Home health care</td>
<td>You pay 20%, plan pays 80%; deductible does not apply</td>
<td>You pay 25%, plan pays 75%; deductible does not apply</td>
<td>Pre-service notification is required out-of-network Unlimited visits</td>
</tr>
<tr>
<td></td>
<td>• Hospice care</td>
<td>You pay 20% after the deductible; plan pays 80%</td>
<td>You pay 40% after the deductible; plan pays 60%</td>
<td>Pre-service notification is required for inpatient stays Unlimited visits</td>
</tr>
<tr>
<td>You get a vision exam</td>
<td>• Eye exam only</td>
<td>You pay 20% after the deductible; plan pays 80%</td>
<td>No out-of-network benefits</td>
<td>Covers in-network exams only, once every two years. Separate vision coverage is available through VSP</td>
</tr>
</tbody>
</table>
Additional Covered Expenses

Coverage for many conditions listed below depends upon where health services are performed (e.g., doctor’s office, lab and x-ray expenses, hospital charges). Benefits related to the following conditions are paid in the same way benefits are paid for other conditions described in this summary:

- Participation in clinical trials for cancer or another life-threatening disease or condition; cardiovascular health; and surgical disorders of the spine, hip, and knees
  Clinical trials require pre-service notification for both in-network and out-of-network providers
- Treatment of diabetes and related conditions
- Obesity surgery
  Pre-service notification is required for both in-network and out-of-network providers
- Reconstructive procedures
  Pre-service notification is required for out-of-network providers
- Temporomandibular joint (TMJ) services
  Pre-service notification is required for out-of-network providers

Neurobiological/autism spectrum disorders

Covered expenses include inpatient and outpatient treatment and assistive communication devices. In-network, you pay 20% after the deductible; the plan pays 80%
Out-of-network, you pay 40% after the deductible; the plan pays 60%

Pre-service notification is required for out-of-network services (inpatient and outpatient)

Prosthetic devices

The purchase of each type of device is limited to once every three years. In-network, you pay 20% after the deductible; the plan pays 80%. Out-of-network, you pay 40% after the deductible; the plan pays 60%

Transplantation services

In-network: you pay 20% after the deductible; the plan pays 80%. In order for transplants to be covered at the in-network benefit level, the transplant must be performed at a designated facility (UHC Center of Excellence). Members have the option to use a non-designated facility but the out-of-network benefit will apply
Out-of-network: you pay 40% after the deductible; the plan pays 60%

Pre-service notification is required for both in-network and out-of-network providers at a designated transplant facility
Prescription Drugs

Prescription drugs are categorized as Tier 1, 2, or 3. Generally, Tier 1 includes generic and lowest-cost brand-name drugs, Tier 2 includes preferred brand-name drugs, and Tier 3 drugs are the newest, most expensive drugs. Prescription drugs are subject to the plan deductible. Once the deductible is met, copays apply. The copay amounts depend on the drug tier and whether the drug is purchased via retail or mail order.

<table>
<thead>
<tr>
<th>Tier</th>
<th>Retail copay 31-Day Max</th>
<th>*Mail-order copay 90-Day Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>$10</td>
<td>$25</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$35</td>
<td>$87.50</td>
</tr>
<tr>
<td>Tier 3</td>
<td>$60</td>
<td>$150</td>
</tr>
</tbody>
</table>

*Not all prescriptions are available via mail order.

Network pharmacies

The extensive UHC pharmacy network includes major chains, supermarkets, and neighborhood pharmacists. UHC negotiates with participating pharmacies to get the lowest possible costs for plan members. If you go out-of-network, you pay the difference between UHC’s negotiated cost and the amount charged by the out-of-network pharmacy. This cost is applied to your deductible or in addition to your copay.

Additional prescription drug benefits

- Smoking cessation and weight reduction drugs
- Retin-A; covered through age 29, then pre-service notification is required
- Specialty Pharmacy Network
  - Pharmacists available 24/7
  - Timely delivery and shipping in confidential, temperature-sensitive packaging
The Health Savings Account (HSA)

The tax-free HSA is a way to help offset out-of-pocket expenses, especially the deductible. It’s available only to individuals who choose the HSA Option. Key features of the HSA include:

- The University contributes $500 (employee only coverage) or $1,000 (family coverage) as long as you open an HSA account with Optum Bank, a UHC partner.
- You may contribute to the HSA through payroll deductions and/or make lump-sum contributions.
- Your contributions—and the University’s—are tax-free and earn interest.
- You don’t pay taxes when you withdraw funds to cover eligible expenses.
- You can choose whether to save or spend the funds in your HSA.
- The rollover of unused funds makes it easy to save for future health care expenses.
- The account is always yours, even if you leave the University.
- You can only withdraw up to the amount funded to your account.

Opening an HSA

Optum Bank provides HSA enrollment materials to all individuals who choose the HSA Option. If you don’t open your HSA when you are first eligible, you will be ineligible for the University’s contribution to your HSA.

HSA contributions

The University makes its full contribution to your HSA on your coverage effective date, provided you have opened your HSA. Contributions are prorated for individuals who are not covered under the HSA Option for an entire year (for example, new hires).

You are eligible for the University’s contribution to your HSA regardless of whether you choose to contribute on your own. You may add to your interest-bearing HSA balance in several ways:

- Payroll contributions
- Electronic transfers from another bank account
- A personal check—from you or someone contributing on your behalf
- A rollover of funds from another HSA if you have one

You may start, change, or stop your HSA contributions at any time.
HSA Contribution Limits

The IRS sets the maximum amount that can be contributed to an HSA each year. This maximum includes contributions from both employee and employer. Below are the maximum amounts for 2015:

<table>
<thead>
<tr>
<th>HSA coverage level</th>
<th>2015 HSA contribution limit</th>
<th>Fordham’s contribution*</th>
<th>Your maximum 2015 contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>$3,350</td>
<td>$500</td>
<td>$2,850</td>
</tr>
<tr>
<td>Family</td>
<td>$6,650</td>
<td>$1,000</td>
<td>$5,650</td>
</tr>
</tbody>
</table>

If you are age 55 or older, you may make an additional catch-up contribution of up to $1,000 a year.

Accessing HSA funds

You may use an HSA debit card for eligible expenses wherever MasterCard® is accepted. You may also:

- Pay bills from your account online
- Pay expenses up front and then request reimbursement online or by withdrawing funds with your debit card from any ATM with the MasterCard® logo
- Write a check from your HSA (checks are available for an additional fee)

You may withdraw any amount up to your HSA balance. Be sure to save your receipts when you make purchases from your HSA.

If you don’t have sufficient funds to pay for an eligible expense, you pay the expense with after-tax dollars. Once funds are back in your account, you can request reimbursement or make an ATM withdrawal to cover all or part of the expense. In this case, you will need to submit a receipt to validate your request. You may choose to pay some or all of your out-of-pocket expenses with after-tax dollars, allowing your HSA funds to grow.

For information about eligible HSA expenses, see IRS Publications 502 and 969 on IRS.gov/publications.
Exclusions

Aside from preventive care, the Choice Plus HSA Option is intended to cover expenses that result from illness or injury. Below is a list of expenses that are not covered under the plan.

- Dental care, unless it is related to an accidental injury or disease
- Routine foot care, except for individuals who are at risk of neurological or vascular disease related to another health condition, such as diabetes
- Personal care for comfort or convenience
- Cosmetic surgery or other treatment
- Health care services provided by an immediate family member
- Health care services provided by another plan, such as Medicare or worker’s compensation
- Health services provided outside the United States, except in an emergency
- Custodial or rest care
- Eyeglasses and contact lenses
- Health services and supplies that are not deemed to be medically necessary

Your plan document has complete details about covered services and supplies, limitations and conditions, and exclusions.