Welcome to Your Fordham Benefits

Fordham University is committed to the physical, emotional, and financial health of its employees. We are also committed to responsible stewardship of its resources. This means ensuring that our medical plan options remain attractive and affordable—for you and for the University—year over year.

Our benefits are designed to provide support for every life stage and lifestyle in our community: single, married, or in a domestic partnership; with or without children; new to the workforce; or getting ready to retire.

Fordham University offers you a comprehensive set of benefit choices. When you enroll, you’ll choose among:

- Two medical plan options with prescription drug coverage
- One dental plan option
- Health Care, Limited Purpose and Dependent Care Flexible Spending Accounts (FSAs)

The University also provides several Automatic Benefits:

- Travel Assistance Resources
- Employee Assistance Program (EAP)
- Critical Illness Benefit
- Identity Theft Protection

The University community will also benefit from Health Advocate, an objective resource to help you navigate the health care system and obtain the best care for you and your family at no cost to you.

About This Guide

This guide describes your benefit options and Automatic Benefits. It also explains how to make your choices using the University’s online enrollment process. Take advantage of the guide and other enrollment resources to determine which options provide the best fit for you and your family. Be sure to use the glossary on page 23 for the definition of terms.

If you have questions during Open Enrollment, you may call Fordham University Benefits at (718) 817-4930, Monday through Friday from 9 a.m. to 5 p.m. Eastern Time.
ITEMS TO CONSIDER FOR 2019

For Current Employees

Open Enrollment begins October 29 and ends November 16, 2018. It’s your annual opportunity to make benefit selections that are best for your needs.

Take the Opportunity to Review Your Benefits
Your 2018 benefits will roll over into 2019 with the exception of your Flexible Spending Account and Health Savings Account contributions. Use this year’s Open Enrollment as your opportunity to review your current coverage to ensure it’s meeting your needs.

For New Hires

Welcome to your Fordham benefits. At Fordham, we offer you a choice of two medical plan options through UnitedHealthcare: the Health Investment Option and the Enhanced Standard Option. Review this guide for information on the Medical Plan options and how they work, and other benefits available to you.

You have 30 days to enroll in your benefits from your initial date of hire. If you do not make an active election, you will not have the opportunity to enroll until the next Open Enrollment period.

Tools and Resources

Use the following resources to make the most of your Fordham benefits:

• Videos – A series of short, informational videos about your medical options:
  - “Health Insurance 101”
  - “About the Health Investment Option”
  - “HSA Overview”
  - “HSA for Long-term Savings”
• User guides for the Health Investment Option and Enhanced Standard Option to help you make the most of your coverage throughout the year:
The University offers two medical coverage options through UnitedHealthcare's (UHC) Choice Plus network. The plan pays the highest level of benefits when you receive care from providers (e.g., doctors, hospitals, lab facilities) in the UHC Choice Plus network. Both options provide 100 percent coverage in-network for preventive care services.

Choose from two medical coverage options:

- Health Investment Option
- Enhanced Standard Option

The Health Investment Option is a consumer-directed health insurance plan (CDHP) option. The Health Investment Option has a higher deductible than the Enhanced Standard Option. The deductible applies to most covered expenses. Once the deductible is met, you and the plan share remaining expenses. You pay more toward the cost if you go out-of-network for care. A key feature of this option is the Health Savings Account (HSA). When you open an HSA, the University makes a contribution to help pay your out-of-pocket expenses. You may add your own tax-free contributions to your HSA through making pre-tax payroll deductions, and you may use the account for current or future health care expenses. Choosing this option means you will not be eligible for a Health Care Flexible Spending Account (FSA), but you will be able to open a Limited Purpose FSA.

The Enhanced Standard Option is a Preferred Provider Organization (PPO) health insurance plan that is paired with a Health Reimbursement Account (HRA), a type of employer-funded account that reimburses employees for out-of-pocket health care expenses. Most services are subject to a copay or deductible and coinsurance. A small copay is required for doctors’ office visits. Reduced benefits are available if you receive out-of-network care. Only the Enhanced Standard Option covers these services:

- Advanced infertility treatment
- Unlimited rehabilitative services (physical therapy, speech therapy, chiropractic care, occupational therapy)
- Out-of-network charges reimbursed at the 90th percentile of usual, customary, and reasonable charges

Remember, both options pay the full cost of in-network preventive care.
You might be wondering...

<table>
<thead>
<tr>
<th></th>
<th>Health Investment Option</th>
<th>Enhanced Standard Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the plan cover both in- and out-of-network providers?</td>
<td>Yes*</td>
<td>Yes*</td>
</tr>
<tr>
<td>Is there an in-network deductible?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Will I pay more for coverage or more for care?</td>
<td>Care (when you pay for services)</td>
<td>Coverage (through payroll deductions)</td>
</tr>
<tr>
<td>Is preventive care free to me?</td>
<td>Yes, in-network</td>
<td></td>
</tr>
<tr>
<td>Will I pay a fixed copay or coinsurance** for non-preventive care in-network?</td>
<td>Coinsurance</td>
<td>Copay or coinsurance, depending on the type of expense</td>
</tr>
<tr>
<td>What is my limit for out-of-pocket expenses?</td>
<td>In-network: $3,000 employee-only, $6,000 family</td>
<td>In-network: $2,500 employee-only, $5,000 family</td>
</tr>
<tr>
<td></td>
<td>Out-of-network: $6,000 employee-only, $12,000 family</td>
<td>Out-of-network: $2,500 employee-only, $5,000 family</td>
</tr>
<tr>
<td>What type of accounts can I use to pay eligible expenses tax-free?</td>
<td>Health Savings Account, Limited Purpose Flexible Spending Account</td>
<td>Health Reimbursement Account, Health Care Flexible Spending Account</td>
</tr>
<tr>
<td>What makes this option special?</td>
<td>An increasingly popular plan option</td>
<td>Very low out-of-pocket costs</td>
</tr>
<tr>
<td></td>
<td>Features a tax-free HSA with contributions from the University and plan participants</td>
<td>Benefits for advanced infertility treatment and unlimited rehabilitative services (physical therapy, speech therapy, chiropractic care, occupational therapy)</td>
</tr>
<tr>
<td></td>
<td>Encourages long-term planning and saving for health expenses</td>
<td></td>
</tr>
</tbody>
</table>

* The plan pays the highest level of benefits when you stay in-network for care.
** Coinsurance refers to the way you and the plan share costs after the deductible is met. For example, if the plan pays 80 percent, your coinsurance is 20 percent.

Family Deductibles Work Differently

If you enroll in family coverage, note that the family deductible works differently for the two options.

- In the **Health Investment Option**, you must meet the family deductible before the plan begins paying benefits for anyone in the family.
- In the **Enhanced Standard Option**, the plan begins paying benefits for any individual once the employee-only deductible is met. The plan will then pay benefits for all covered family members once the entire family deductible is met.
On the following pages, take a closer look at the key elements that differentiate your plan options. The Health Investment Option plan members typically pay for non-preventive care until they reach their deductible and then share the cost with the plan through coinsurance—up to the out-of-pocket maximum. With the Enhanced Standard Option, most services are subject to a copay or deductible and coinsurance. For both options, an out-of-pocket maximum limits the amount you pay in deductibles, coinsurance and copayments for the year. If you reach this limit, the plan pays 100% of any additional covered charges for the year.

Health Investment Option

The Health Investment Option is a consumer-directed health plan—or CDHP for short. It features a high deductible and a Health Savings Account (HSA). In exchange for lower payroll contributions, and a Fordham-funded HSA, CDHP participants pay a higher share of up-front costs for care, so they have more incentive to understand care and treatment options, evaluate alternatives, and take advantage of free preventive care benefits.

With a $1,500 employee-only/$3,000 family in-network deductible, our Health Investment Option meets the minimum requirement for a high-deductible health plan. Otherwise, you could not be offered the HSA feature.

The Health Investment Option qualifies you to participate in up to two tax-free accounts: an HSA with automatic contributions from Fordham, and a Limited Purpose FSA. Be sure to understand how the two accounts work before making your contribution elections.
The Health Savings Account (HSA)
The tax-free HSA is a way to help offset higher out-of-pocket expenses, especially the deductible. It’s available only to individuals who choose the Health Investment Option. If you make that choice, here’s how you will benefit from the HSA:

• The University will make an annual contribution of $750 (employee-only coverage) or $1,500 (family coverage) as long as you activate your HSA account through Discovery Benefits. This amount will be prorated for new hires.

• You may contribute to the HSA through payroll deductions and/or make lump-sum contributions. Please note: you are responsible for managing your HSA contributions so that your balance does not exceed the annual IRS limit.

• 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 make a withdrawal only up to the amount funded in your account.

HSA Contribution Limits
The IRS sets the annual HSA contribution limits each year. This limit includes contributions from both employee and employer. Here are the maximum amounts for 2019:

<table>
<thead>
<tr>
<th>HSA Coverage Level</th>
<th>2019 HSA Contribution Limit</th>
<th>Fordham’s Contribution</th>
<th>Your Maximum 2019 Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee-only</td>
<td>$3,500</td>
<td>$750</td>
<td>$2,750</td>
</tr>
<tr>
<td>Family</td>
<td>$7,000</td>
<td>$1,500</td>
<td>$5,500</td>
</tr>
</tbody>
</table>

The University will make its full contribution to your HSA on January 1, 2019, provided you have activated your HSA. Fordham’s contribution is prorated for new hires. If you are age 55 or older at any time in 2019, you may make an additional catch-up contribution of up to $1,000 a year regardless of which coverage level you have chosen.

HSA Eligibility
According to IRS regulations, you cannot enroll in an HSA if...

• You are not enrolled in the Health Investment Option.

• You and/or your spouse has a Health Care Flexible Spending Account (FSA) or Health Reimbursement Account (HRA) to pay for medical expenses.

• You are claimed as a dependent on anyone else’s tax return.

• You are enrolled in Medicare*. If you are approaching age 65, keep this in mind before making your HSA elections.

*Employees age 65+ are automatically enrolled in Medicare Part A if they receive Social Security benefits

Use Your Health Care FSA Funds by December 31, 2018
In order to contribute to your HSA and receive contributions from the University beginning January 1, 2019, you must have a zero dollar balance in your Health Care FSA by December 31, 2018. Otherwise, you will not be able to make or receive contributions until April 1, 2019. This is a special rule imposed by the IRS.
Activating Your HSA
When you enroll in the Health Investment Option for the first time, you will be able to activate an HSA through Discovery Benefits. You must activate your HSA in order to receive the University’s contribution even if you choose not to add your own dollars. If you sign up during the open enrollment period, the University’s full contribution to your HSA will be available at the beginning of the plan year. After you activate your HSA, you will receive a welcome package to help you manage the HSA moving forward.

Growing Your HSA
You are eligible for the University’s contribution to your HSA regardless of whether you choose to contribute on your own. With the tax savings—and an opportunity to save for future health care expenses—most HSA plan participants are eager to contribute to the account. You may add to your HSA balance through:

• Pre-tax 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 will be able to sign up for payroll contributions when you elect the option. You may start, change, or stop your HSA contributions at any time. The HSA also earns interest. If you continue to save rather than spend your HSA dollars, you may be eligible to invest in mutual funds.

Using Your HSA
There are several ways to access your HSA funds. When you activate your HSA, you will receive an HSA debit card. You may use the card to pay eligible expenses where Visa is accepted, and you can order extra cards for family members. You may also:

• Pay bills from your account online
• Pay expenses up front and then request reimbursement online

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 will pay the expense with after-tax dollars. Once funds are back in your account, you can request reimbursement to cover all or part of the expense. In this case, you will need to submit a receipt to validate your request.

Spend or Save
While the HSA can be used to fund immediate health care expenses, it’s a great tool for smart planners too. With tax-free personal savings and the University’s contributions, your HSA can grow quickly and offer extra financial security during retirement. Many plan participants choose to pay some or all of their out-of-pocket expenses with after-tax dollars, allowing HSA funds to grow.

For information about eligible HSA expenses, see IRS Publication 502 on IRS.gov/publications.

WAYS YOU CAN SAVE ON TAXES
If you’re looking for ways to save, consider the following options:

• **HSA** – An HSA has triple tax advantages: money goes in, grows, and can be withdrawn tax-free.

• **Health Care and Limited Purpose FSAs** – You can make pre-tax contributions from your paycheck to these accounts.

To see how you can save, use the Tax-Savings Calculator feature on the Medical Plan Cost Estimator.
Enhanced Standard Option

The Enhanced Standard Option is focused on current-year expenses. It combines medical coverage with a Health Reimbursement Account (HRA). With the Enhanced Standard Option, some services are subject to a copay while others are subject to deductible and coinsurance. Only the Enhanced Standard Option provides additional benefits for advanced infertility treatment and outpatient rehabilitative services.

Infertility Treatment

Basic infertility services are covered under both medical options, but only the Enhanced Standard Option offers a $10,000 maximum lifetime benefit per person for ovulation induction, assisted reproductive technologies (ART), and outpatient pharmaceutical products that need to be administered by a health care professional.

Note: These expenses are not covered under the Health Investment Option.

Outpatient Rehabilitative Services

There is no limit to the number of times you are eligible to access services such as chiropractic care; physical, occupational, and speech therapy; pulmonary and cardiac therapy; and vision therapy. The Health Investment Option, however, limits rehabilitative services to 60 visits per therapy.

The HRA

The HRA reimburses you for out-of-pocket expenses such as your plan’s deductible, copays, and coinsurance, as well as dental care. For information about eligible HRA expenses, see IRS Publication 969 on IRS.gov/publications.

An HRA offers the following features...

- **Fordham contributions only.** Only Fordham contributes tax-free to an HRA: $400 for employee-only and $800 for family coverage. Note: If you are a new hire, your contribution will be prorated based on your date of hire. Employee contributions are not permitted.
- **Tax advantages.** You pay no taxes on the money Fordham contributes to your account.
- **Rollover of unused HRA balance (limited).** If you have any funds remaining in your HRA at year-end, they will roll over to the following year (up to December 31, 2020).
- **Account access if you leave (limited).** You have access to your HRA for up to one year following your last date of employment (but no later than December 31, 2020).
- **Eligibility for a Health Care FSA.** While you cannot contribute to an HRA, you can make tax-free contributions to a Health Care FSA, up to IRS limits. See page 16 to learn more.

You are able to access 100% of the annual HRA amount (plus any rollover from prior years) on January 1. If you leave Fordham, you cannot withdraw funds from your HRA, instead you will have limited access to your remaining HRA balance for up to one year after you terminate employment.
Finding an In-Network Provider

You may be wondering whether your doctor participates in the UHC Choice Plus network. Since UHC has network contracts with 94.4 percent of the providers who currently serve our community, there is a good chance your doctor is among them. **Note:** The provider network remains the same as it was in 2017. So, if you were seeing a UHC Choice Plus doctor in 2017, you’ll most likely be able to continue seeing your provider in 2019.

If you are currently enrolled in a medical plan option through the University, visit [myuhc.com](http://myuhc.com) to search for providers and explore your other resources from UHC.

You don’t need to be a plan member to search for providers. Visit [welcometouhc.com](http://welcometouhc.com), select Find a Doctor, and select Choice Plus. You can search by name or a variety of other criteria. You may also call (866) 633-2446 to speak with a customer care professional who can help you search for a doctor.

If your current provider is not in the network, you can ask that he or she be considered. The University’s HR department can guide you on how your provider can apply to join the UHC network.

Pre-Service Notification

To be sure you receive the maximum benefits available, you or your provider must contact UHC before you receive certain services or treatments. All it takes is a simple phone call that you or the provider can make just once before the service or treatment.

- If you go to an out-of-network provider, you are responsible for contacting UHC directly. Dial (866) 633-2446 if you are in the Health Investment Option or (866) 314-0335 for the Enhanced Standard Option.
- If you are in-network, your provider will notify UHC directly on your behalf.

For a detailed list of services that require pre-service notification, see page 23.
### Fordham University Medical Plan Options

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>Health Investment Option</th>
<th>Enhanced Standard Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In Network</td>
<td>Out of Network</td>
</tr>
<tr>
<td><strong>Tax-Advantaged Account</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Account type</td>
<td>Health Savings Account (HSA)</td>
<td>Health Reimbursement Account (HRA)</td>
</tr>
<tr>
<td>Fordham contributions</td>
<td>Employee-only: $750</td>
<td>Employee-only: $400</td>
</tr>
<tr>
<td></td>
<td>Family: $1,500</td>
<td>Family: $800</td>
</tr>
<tr>
<td>Your contributions</td>
<td>See page 7 for how much you can contribute</td>
<td>Not permitted</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee-only</td>
<td>$1,500</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Family</td>
<td>$6,000</td>
<td>$12,000</td>
</tr>
<tr>
<td><strong>Coinsurance and Copays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>No cost to you</td>
<td>No cost to you</td>
</tr>
<tr>
<td>Office Visit: PCP and Specialist</td>
<td>You pay 40% after deductible</td>
<td>Primary care: $25 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specialist: $50 copay</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>You pay 20% after deductible</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Outpatient Diagnostic Testing</td>
<td>You pay 20% after deductible</td>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>Hospital Inpatient Care</td>
<td>You pay 40% after deductible</td>
<td>$250 copay</td>
</tr>
<tr>
<td>Most Other Covered Services</td>
<td>You pay 40% after deductible</td>
<td>You pay 5% after deductible</td>
</tr>
</tbody>
</table>

Both options provide coverage for hearing aids. Benefits include a single purchase, including repair and replacement, per hearing-impaired ear every three years.
PRESCRIPTION DRUGS

Both medical options offer coverage for prescription drugs. Each plan has three prescription copay levels, or tiers.

- Tier 1 is the lowest-cost option and typically includes generic drugs and the lowest-cost brand-name drugs.
- Tier 2 is the midrange cost option and includes most preferred brand-name drugs.
- Tier 3 is the highest-cost option and includes drugs that are usually the newest and most expensive—typically considered non-preferred, brand-name drugs.

To get the best value from the plan, try to choose the lowest-cost tier whenever possible. If your doctor prescribes a Tier 3 drug for you, you may want to ask whether there is a lower-cost alternative in Tier 1 or Tier 2 that would provide the same benefits. Your copay amounts will also vary depending on whether prescriptions are purchased retail or via mail order.

The Enhanced Standard Option does not require a deductible for prescription drugs. In the Health Investment Option, prescription drugs apply toward the medical plan deductible. After the deductible has been met, you pay copays. Under both options, prescription drug copays count toward the in-network medical plan out-of-pocket maximum. If a covered plan member reaches the out-of-pocket maximum, prescription drugs will be covered at 100 percent for the rest of the year.

The chart below shows your share of the cost for each prescription drug tier in detail.

<table>
<thead>
<tr>
<th>Prescription Drug Copay Amounts by Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drug Category</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Tier 1</td>
</tr>
<tr>
<td>Tier 2</td>
</tr>
<tr>
<td>Tier 3</td>
</tr>
</tbody>
</table>

* For the Health Investment Option, the copays for drugs apply after the deductible is met. The deductible does not apply to prescription drugs for the Enhanced Standard Option.

Use a Network Pharmacy to Get Maximum Value

UHC has an extensive network of pharmacy partners—from major chains and supermarkets to neighborhood pharmacists. UHC negotiates with participating pharmacies to get the lowest possible costs for plan members. If you visit an out-of-network pharmacy, you’ll pay more for prescription drugs. Specifically, you’ll pay the applicable copay plus the difference between UHC’s negotiated cost and the amount charged by the out-of-network pharmacy.
How Are Tiers Determined?

UHC continually studies the prescription drug marketplace to determine which drugs bring the highest value to patients. Measurements involve weighing drug costs against outcomes. When brand-name drugs are replaced with generics, the generic drugs typically add more value—providing the same chemical compound at a fraction of the cost. Those medications generally are considered Tier 1. Tier 2 drugs tend to be brand-name drugs for which UHC can negotiate the best prices. Tier 3 are expensive brand-name drugs with little or no pricing advantages and no effective generic equivalents.

To give you an example of how a group of drugs may be classified, consider statins, which are prescribed to treat high cholesterol. American Heart Association cholesterol guidelines recommend high- or moderate-intensity statins. Atorvastatin, a generic compound, can be high or moderate depending on the dose, so most individuals can be treated with this Tier 1 option. Below are common statins available in each tier:

**Tier 1:** Atorvastatin, Simvastatin, Pravastatin  
**Tier 2:** Praluent  
**Tier 3:** Livalo

Explore UnitedHealthcare’s resources!  
If you are a plan member, visit myuhc.com. If you are not a plan member, visit welcometouhc.com.
DENTAL PLAN

The University offers the Dental Health Maintenance Organization (DHMO), administered by Cigna, at no cost to you. The plan pays benefits only when you receive care from providers in the Cigna DHMO network. To find participating dental care providers, go to [http://hcpdirectory.cigna.com](http://hcpdirectory.cigna.com).

The following chart shows your share of the cost for common covered expenses under the DHMO.

<table>
<thead>
<tr>
<th>Service/Plan Feature</th>
<th>DHMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>In-Network</td>
</tr>
<tr>
<td>Preventive and Diagnostic Care</td>
<td>None</td>
</tr>
<tr>
<td>Basic Restorative Care</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Major Restorative Care</td>
<td>Plan does not provide out-of-network benefits</td>
</tr>
<tr>
<td>Orthodontia</td>
<td></td>
</tr>
</tbody>
</table>

Calendar Year Maximum: No maximum plan benefit

*The DHMO Dental Patient Charge Schedule is available on [www.fordham.edu/benefits](http://www.fordham.edu/benefits). To give you an idea of what your cost might be for certain services, resin-based fillings and crowns range from $40 to $75, metallic and porcelain crowns range from $185 to $225, pulp removal is $10, and periodontal scaling is $30 to $50. Upper or lower dentures range from $275 to $325, depending on whether they are partial or full, and extractions range from $10 to $70.*
FLEXIBLE SPENDING ACCOUNTS (FSAs)

If you want to participate in a Flexible Spending Account (FSA), you must make a contribution election every year at my.fordham.edu. FSA elections do not roll over from year to year.

FSAs let you set aside part of your pay before most taxes are withheld to pay certain types of expenses. This arrangement lowers the amount of your pay that is taxed. You still have the same expenses you would have without the accounts, but you save money by paying less in taxes. Fordham offers three different types of FSAs. Read this section to find which apply to you.

Health Care FSA

The Health Care FSA is available to employees who enroll in the Enhanced Standard Option or those who do not enroll in any medical plan, and is for your share of expenses that are not paid by your medical and dental plans such as deductibles, coinsurance, and copays. You don’t need to be covered under the University medical plan to participate in the Health Care FSA. The following is a summary of how the account works, based on IRS guidelines:

• You may contribute up to $2,650 a year to your Health Care FSA. The minimum annual contribution is $120.
• Your contributions are made in equal installments each pay period before most taxes are withheld.
• As you incur eligible expenses, you may request reimbursement from your account, up to the full amount you have elected to set aside for the year. You can also make payment at the time of service with a special debit card. You have access to the entire elected amount on January 1.
• The account you set up may be used for claim expenses you incur through March 15 of the following year. You will then have until April 30 to submit all claims.
• Funds remaining in your account after April 30 will be forfeited.

If you are married, you and your spouse may each set up a health care FSA through your own employer and contribute the maximum amount under each plan.

Limited Purpose FSA

The Limited Purpose FSA provides another way to pay eligible expenses with pre-tax dollars, if you enroll in the Health Investment Option.

Eligible expenses include:

• Your share of expenses that are not paid by your dental plan, such as deductibles, coinsurance, and copayments.
• Vision care expenses, such as exams, prescription eyeglasses and sunglasses, prescription contact lenses, and laser surgery, which are not covered by your medical or vision plan.

The following is a summary of how the account works, based on IRS guidelines:

Sections continued on next page >
You may contribute up to $2,650 a year to your Limited Purpose FSA. The minimum annual contribution is $120.

Your contributions are made in equal installments each pay period before most taxes are withheld.

As you incur eligible expenses, you may request reimbursement from your account, up to the full amount you have elected to set aside for the year. You can also make payment at the time of service with a special debit card.

The account you set up may be used for claim expenses you incur through March 15 of the following year. You have until April 30 of the following year to submit all claims.

Funds remaining in your account after April 30 of the following year will be forfeited.

Dependent Care FSA

The Dependent Care FSA helps you pay for the care of a qualified dependent while you and your spouse (if applicable) work. The Dependent Care FSA is available to you regardless of which medical plan option you choose, even if you waive medical coverage through Fordham. Qualified dependents include children and elders you claim as tax dependents.

The following is a summary of how the account works:

- You may contribute up to $5,000 a year per family to your Dependent Care FSA. (If you are married but file separate income tax returns, the maximum contribution is $2,500.) The minimum annual contribution is $120.
- Your account contributions are made in equal installments each pay period.
- As you incur eligible expenses, you may request reimbursement from your account up to the amount of your account balance.
- You may use the account to pay for the care of dependent children up to age 13 or for an elderly or disabled dependent who relies on you for support.
- Qualified expenses include child and adult day-care centers, a licensed in-home provider, summer day camps, and before- and after-school programs.
- The account you set up may be used for claim expenses you incur through March 15 of the following year. You have until April 30 of the following year to submit all claims.
- Funds remaining in your account after April 30 of the following year will be forfeited.

IRS Guidelines for Health Care, Limited Purpose, and Dependent Care FSAs

In exchange for significant tax advantages, the IRS restricts the use of FSAs as follows:

- Unused FSA funds cannot be returned to you.
- Accounts must be completely separate. You can’t take money from the Health Care or Limited Purpose FSA to pay dependent care expenses or vice versa.
- You can’t take a tax credit for any dependent care expense you fund through your Dependent Care FSA.

For more information and a full list of eligible health care and dependent care FSA expenses, log on to http://www.irs.gov/Forms-&-Pubs.
**Automatic Benefits**

Although you will make important choices about health care benefits during Open Enrollment, several other programs add value to the University benefits program. The majority of these services are paid for entirely by the University and offer personal and financial security in a number of areas.

### Health Advocate

**Health Advocate** is an objective partner to help you navigate the complex world of health care. From understanding complicated treatment options and managing health insurance claims to getting the best value for your health care dollars, a Health Advocate counselor can ease some of the fears and stress that come with health-related events.

### Employee Assistance Program (EAP)

The University offers an **EAP** to benefits-eligible employees, which is available online, via the website or the myACI app, and by phone 24 hours a day, seven days a week.

The EAP can help you with:
- Child and elder care support, such as in-home care
- Parenting and family issues
- Stress management
- Bereavement
- Work-related challenges
- Legal and financial issues, such as credit or debt counseling

The program offers counseling services and a wealth of online resources, such as articles, community-based referrals, and discounts. You don’t need to be covered under the University’s health care plans to use the EAP, and services are available to your extended family members as well.

EAP services are entirely confidential. In addition, you are eligible for Care24 EAP through UnitedHealthcare. If you are covered by one of the medical options, contact information for Care24 can be found on the back of your ID cards from UnitedHealthcare.

### Critical Illness Coverage

A major illness such as cancer, heart attack, or stroke can have a devastating financial impact on an individual or family. To help offset some of those unforeseen costs, the Critical Illness benefit through First Reliance Standard provides a waiver of Life Insurance premiums and a one-time lump-sum payment. The lump-sum payment equals 10 percent of your Basic Life Insurance amount, to a maximum benefit of $100,000. If you receive a lump-sum payment from the plan, it will not lower the value of your Life Insurance policy.

### Identity Theft Protection

Identity theft is the fastest-growing crime in the U.S. If you are a victim, First Reliance Standard will assign you a Privacy Advocate who will investigate your case, notify creditors on your behalf, issue fraud alerts, and make sure your credit and all personal records are restored to their full integrity.
**24-Hour Travel Assistance**

If you are traveling more than 100 miles from home, you can reach out to On Call, a First Reliance Standard partner, for help with emergencies.

On Call can help you prepare for a trip abroad with information about vaccines, passport and visa requirements, currency exchange rates, weather and hazard advisories, and U.S. embassy contacts. While you are traveling, On Call can help arrange emergency medical transportation, referrals and services, and support for emergency personal situations, such as lost luggage or a lost passport.

**TOOLS AND RESOURCES FROM UNITEDHEALTHCARE**

UnitedHealthcare offers tools and resources to help us all become better health care consumers. One reason the University partners with UHC is its user-friendly website and health management tools and support programs. As a Choice Plus network member, you have access to:

- myuhc.com, where you can find articles, videos, quizzes, a health assessment tool, preventive care guidelines, detailed plan summaries, prescription drug information, health care reform updates, and answers to a broad range of health-related questions.
- A registered nurse, 24 hours a day, seven days a week at (800) 828-1120.
- Personalized help for maternity patients through pregnancy and delivery.
- Resources to help you find a doctor.
- A cost estimator to help you plan for a medical procedure.
- Mobile apps so you can access UHC services, as well as your claims and health information, on your mobile devices.
- An action plan to help you chart your own path toward a healthy lifestyle.
Eligibility and Enrollment

WHO’S ELIGIBLE FOR BENEFITS

All Clerical Local 153 members are eligible to enroll in the University Benefits Program. If you are a new hire, you become eligible after a 90-day waiting period.

COVERING YOUR DEPENDENTS

You may enroll your eligible dependents for medical and dental coverage. Your dependents include your:

- Spouse
- Biological or adoptive child or stepchild under age 26
  - A child placed for the purposes of adoption and any other child whom state or federal law requires be treated as a dependent
  - Married dependent children are eligible for medical coverage only. The spouse of your eligible, married dependent child is not eligible for coverage
- An unmarried, disabled dependent of any age who is incapable of self-care or employment and depends on you primarily for support
ENROLLING FOR COVERAGE

Open Enrollment begins October 29 and ends November 16, 2018.

One of the first things to think about is how and when you want to share in the cost of coverage.

• The Enhanced Standard Option offers comprehensive coverage for services that are subject to the deductible, copays and coinsurance, in exchange for higher payroll contributions.
• If you elect the Health Investment Option, you will share in more of the cost when you receive health care services, but your payroll contributions will be lower.

Things to Consider

As you work through the decision process, consider or take the following actions to help you decide which plan is best for you:

• Take another look at the medical plan options. Remember that your true cost is the combination of your out-of-pocket costs and biweekly contributions.
• Do you have predictable expenses, such as planned surgery or a medication you take for an ongoing condition? How would the plans meet your needs for those expenses?
• Are you prepared for unusual circumstances? Think about what would happen if you have a major, unexpected health expense. At the same time, keep in mind that all plans provide an out-of-pocket limit as a safety net for catastrophic expenses.
• Remember that the University will contribute to an HSA, and you may contribute to both the HSA and a Limited Purpose FSA, if you choose the Health Investment Option.
• Could a Health Care FSA help offset out-of-pocket expenses?
• Look at the benefits available through your spouse’s employer. Does it make sense for each of you to be covered through your own employer’s plan? What’s the best coverage for your family? If you plan to switch to or from another employer’s plan, make sure you understand that plan’s rules for making midyear changes.

Online Enrollment

With the University’s online enrollment system, you can log on to the system either through my.fordham.edu or any computer that is connected to the Internet. The online enrollment system is accessible all year so you can review your benefit choices, access plan summaries and forms, and review your benefit costs.

Logging on from my.fordham.edu

• Click on the “Human Resources” tab.
• Select the Open Enrollment button to enter the application for making changes.
• Follow prompts to make your choices for each benefit.
• In order to complete your enrollment, be sure to have the following information available for your dependents and beneficiaries:
  – Full name
  – Date of birth
  – Social Security number (for children 1 year old or older)
  – Address (if different from yours)

Enrolling

The system will walk you through enrollment, screen-by-screen. You’ll be asked to do the following:

• Confirm personal information and verify dependents.
• Select benefits. You will see only benefits for which you are eligible.
• See how much you will save in taxes.
• Review a summary of your choices.
• Make changes if necessary.
• Confirm your choices.
Waiving Coverage

You must actively waive coverage for 2019 if you do not wish to be covered by a Fordham University Medical Plan, even if you waived coverage in the past. If you choose to waive coverage, you will receive a stipend of $75 each pay period, or $1,950 per year. You can use this stipend to find coverage elsewhere, if you choose.

The stipends will begin with the first payroll in 2019 and continue through December 31, 2019. To receive the stipend, you will need to provide proof of insurance through another provider.

Changing Your Choices

During your enrollment period, you may log on and change your benefit choices as often as you wish until the enrollment deadline. Each time you make a change, you will see a page confirming your updated choices. Your last confirmed choice, based on the date and time, will determine your coverage choices that will remain in effect until the end of the plan year.

In order to make changes during the year, you must have a family status change, such as:

- Your marriage or divorce
- Your spouse’s death
- The birth, adoption, legal custody, or death of a dependent child
- Gain or loss of coverage due to a change in your or your spouse’s employment status
- End of dependent status for your child

Any benefit change you request must coincide directly with your family status change and be reported to Human Resources (at benefits@fordham.edu) with proof of the family status change within 30 days of the change.
### Other Important Information

#### PRE-SERVICE NOTIFICATION EVENTS

Following is a complete list of medical events for each plan that require such pre-service notification to the plan. “Required” refers to both in-network and out-network. To provide pre-service notification, contact UHC at (866) 633-2446 for the Health Investment Option and (866) 314-0335 for the Enhanced Standard Option.

<table>
<thead>
<tr>
<th>Medical event</th>
<th>Health Investment Option</th>
<th>Enhanced Standard Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congenital Heart Disease Surgery</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Congenital Disease and Anomaly</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Clinical Trials</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Dental Services – Accidental Injury</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Emergency Room Care</td>
<td>Required only for out-of-network</td>
<td>Required only for out-of-network</td>
</tr>
<tr>
<td>• Ambulance Transportation</td>
<td>Required for non-emergency ambulance</td>
<td>Required for non-emergency ambulance</td>
</tr>
<tr>
<td>• Evaluation by Hospital ER Staff; Related Fees for Diagnostic Tests and Treatment</td>
<td>Required if ER visit results in inpatient stay, only for out-of-network</td>
<td>Required if ER visit results in inpatient stay, only for out-of-network</td>
</tr>
<tr>
<td>Infertility Treatment</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Hospital Admittance</td>
<td>Required only for out-of-network</td>
<td>Required only for out-of-network</td>
</tr>
<tr>
<td>Mental Health or Substance Abuse Treatment (Inpatient and Outpatient)</td>
<td>Required only for out-of-network</td>
<td>Required only for out-of-network</td>
</tr>
<tr>
<td>Obesity Surgery</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Required only for out-of-network</td>
<td>Required if inpatient stay is longer than 48 hours after a normal vaginal delivery or 96 hours after a cesarean section delivery, only for out-of-network</td>
</tr>
<tr>
<td>Reconstructive Procedures</td>
<td>Required only for out-of-network</td>
<td>Required only for out-of-network</td>
</tr>
<tr>
<td>Rehabilitative Services (Outpatient)</td>
<td>Required for chiropractic care only for out-of-network</td>
<td>Required for chiropractic care only for out-of-network</td>
</tr>
<tr>
<td>Special Treatment, Equipment, or Care in an Alternative Medical Setting</td>
<td>Required only for out-of-network</td>
<td>Required only for out-of-network</td>
</tr>
<tr>
<td>• Durable Medical Equipment Over $1,000</td>
<td>Required only for out-of-network</td>
<td>Required only for out-of-network</td>
</tr>
<tr>
<td>• Home Health Care</td>
<td>Required only for out-of-network</td>
<td>Required only for out-of-network</td>
</tr>
<tr>
<td>• Hospice Care</td>
<td>Required only for inpatient stays out-of-network</td>
<td>Required only for inpatient stays out-of-network</td>
</tr>
<tr>
<td>• Skilled Nursing and Inpatient Rehabilitation Facility</td>
<td>Required only for out-of-network</td>
<td>Required only for out-of-network</td>
</tr>
<tr>
<td>Temporomandibular Joint (TMJ)</td>
<td>Required only for out-of-network</td>
<td>Required only for out-of-network</td>
</tr>
<tr>
<td>Transplants</td>
<td>Required</td>
<td>Required</td>
</tr>
</tbody>
</table>
GLOSSARY

Coinsurance: The percentage of the cost of covered services you pay after the deductible. For example, if your coinsurance is 20%, you pay 20% of the cost, and the plan pays 80%. Coinsurance varies depending upon whether you obtain in-network or out-of-network care.

Copay: The flat dollar amount you pay for certain services. In the Health Investment Option, copayments apply only to prescription drugs (after you meet the deductible).

Annual Deductible: The amount you pay toward the cost of health care expenses each year before your plan begins to pay benefits on a calendar year basis. You have an in-network and an out-of-network deductible. The deductible does not apply to in-network preventive care.

Dental Health Maintenance Organization (DHMO): A dental option within which all expenses must be incurred in-network. No out-of-network benefits are available.

Flexible Spending Account (FSA): A tax-free account that reimburses expenses in a given plan year. The accounts are funded entirely by plan participants. Funds remaining in your account after a set time will be forfeited.

Health Reimbursement Account (HRA): A tax-free account available to participants in the Enhanced Standard Option only. The University contributes to this account, which can be used to pay current health care expenses, such as your medical plan’s deductibles, copays and coinsurance, as well as dental care expenses. You can rollover unused HRA money to the following year (up until December 31, 2020).

Health Savings Account (HSA): A tax-free account available to participants in the Health Investment Option. The University contributes to the account, and it is used to pay current or future health care expenses. Unused balances roll over from year to year.

Annual Out-of-Pocket Maximum: The maximum amount you pay out-of-pocket for covered medical expenses on a calendar year basis. If you reach this out-of-pocket maximum, the plan pays 100% of all remaining covered costs for the year. This feature provides important financial protection from very high medical expenses by limiting your in-network out-of-pocket costs for the year. You also have an out-of-network out-of-pocket maximum.
VENDOR CONTACTS

During the Open Enrollment period, if you have any questions about your benefits, you may call contact Fordham University Benefits Office at (718) 817-4930, Monday through Friday from 9 a.m. to 5 p.m. Eastern Time, or via benefits@fordham.edu.

For information about claims and plan-specific requests, you are likely best served by contacting our vendors directly. If you have a question or concern that cannot be resolved by the appropriate vendor, please contact the University’s Benefits Office.

<table>
<thead>
<tr>
<th>Benefit/Plan</th>
<th>Vendor/Resource</th>
<th>Website</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Medical Options and Prescription Drugs</td>
<td>UnitedHealthcare</td>
<td>myuhc.com</td>
<td>For the Health Investment Option: (866) 633-2446</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For the Enhanced Standard Option: (866) 314-0335</td>
</tr>
<tr>
<td>Dental</td>
<td>Cigna</td>
<td>cigna.com</td>
<td>(800) 244-6224</td>
</tr>
<tr>
<td>Health Reimbursement Account</td>
<td>Discovery Benefits</td>
<td>discoverybenefits.com</td>
<td>(866) 451-3399</td>
</tr>
<tr>
<td>Flexible Spending Accounts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical Illness Insurance</td>
<td>First Reliance Standard</td>
<td>reliaancestandard.com</td>
<td>(800) 353-3986</td>
</tr>
<tr>
<td>Identity Theft Protection</td>
<td>First Reliance Standard</td>
<td>reliaancestandard.com</td>
<td>(855) 246-7347</td>
</tr>
<tr>
<td>24-Hour Travel Assistance</td>
<td>On-Call International</td>
<td>N/A</td>
<td>In the U.S. (800) 456-3893</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Worldwide, call collect (603) 328-1966</td>
</tr>
<tr>
<td>Employee Assistance Program</td>
<td>Reliance/ACI Specialty Benefits</td>
<td>rsl.acieap.com</td>
<td>(855) RSL-HELP (775-4357)</td>
</tr>
<tr>
<td></td>
<td>UnitedHealthcare Care24</td>
<td>myuhc.com</td>
<td>(888) 887-4114</td>
</tr>
<tr>
<td></td>
<td>(for UHC members only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Advocate</td>
<td>Health Advocate</td>
<td>healthadvocate.com</td>
<td>(866) 695-8622</td>
</tr>
</tbody>
</table>
LEGAL NOTICES

Medicaid and Children’s Health Insurance program (CHIP)

If you or your children are eligible for Medicaid or the Children’s Health Insurance Program (CHIP) and you are eligible for health coverage from the University, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs but who also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your state Medicaid or CHIP office to find out whether premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office, dial (877) KIDS NOW, or go to www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state whether it has a program that might help you pay the premiums for an employer-sponsored plan.

In addition, you will be allowed a special enrollment opportunity if you or your eligible dependents either:

• Lose Medicaid or coverage under CHIP coverage because you are no longer eligible
• Become eligible for a state’s premium assistance program under Medicaid or CHIP

For these new enrollment opportunities, you will have 60 days—instead of 31—from the date of the Medicaid/CHIP eligibility change to request enrollment in the plan. Note that this 60-day extension doesn’t apply to enrollment opportunities other than the Medicaid or CHIP eligibility change.

If you have questions about enrolling in the University plans, you can contact the U.S. Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free (866) 444 EBSA (3272).

Creditable Prescription Drug Coverage and Medicare

The prescription drug coverage listed under the University medical plans is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2017. This is known as “creditable coverage.” Coverage under any of the plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2017 offered through a Fordham University plan and are or become covered by Medicare, you may enroll in a Medicare prescription drug plan later on. You will not face a late enrollment penalty if you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment.

If you or your family members aren’t currently covered by Medicare and won’t become covered by Medicare in the next 12 months, this notice doesn’t apply to you.
HIPAA Privacy Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information, includes virtually all individually identifiable health information held by the plan, whether received in writing, in an electronic medium, or as an oral communication.

The Plan is required by law to maintain the privacy of your health information and to provide you with a notice of the Plan’s legal duties and privacy practices with respect to your health information. If you participate in an insured Plan option, you will receive a notice directly from the insurer. It’s important to note that these rules apply to the Plan, not the University as an employer—that’s the way the HIPAA rules work. Different policies may apply to other University programs or to data unrelated to the health Plan.

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. The amount of health information used or disclosed will be limited to the “minimum necessary” for these purposes, as defined under the HIPAA rules.

The Plan, or its health insurer, may disclose your health information without your written authorization to the University for Plan administration purposes. The University agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Benefits personnel are the only University staff who will have access to your health information for Plan administration functions, including obtaining contribution bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan.

Use and disclosure of your health information other than as authorized under HIPAA will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. Please contact the University Human Resources office if you have any questions about HIPAA.

The Women’s Health and Cancer Rights Act

The University health plans cover mastectomies and certain related reconstructive surgeries. The law requires the University to notify you annually of the availability of this coverage.

Covered women who have mastectomies can elect the following procedures after consulting with their physician. By law they will be covered for the following expenses:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis
- Treatment required as a result of physical complications for all stages of mastectomy, including lymphedemas

Keep in mind that coverage is subject to all the terms of the health plan you elect, including applicable copays, deductibles, and/or coinsurance provisions.
Special Note on Maternity and Newborn Infant Coverage

Federal law requires us to tell you that the University’s medical plans cannot restrict or require you to obtain certification for any length of stay in a hospital in connection with childbirth (for mother or newborn) that is 48 hours or less following a standard delivery or 96 hours following a cesarean delivery.

Also, don’t forget to add your newborn to your medical coverage within 30 days of the birth of the child(ren).

Qualified Medical Child Support Orders

The University will honor a qualified medical child support order (QMCSO) relating to provisions for child support; alimony payments; or marital, domestic partnership, or civil union property rights that may require you to provide medical coverage to an eligible child. If the University receives such an order, you will be notified of how it will be handled with respect to your benefits.