Fordham University Benefit Summary: Choice Plus Health Investment Option

This summary was prepared to help you understand the benefits available through your Choice Plus Medical Plan coverage: Health Investment Option. If you want more detail 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) 817-4930 or benefits@fordham.edu.

The Health Investment 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 Health Investment 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 Health Insurance Association of America, which surveys doctors every six months on their fees. The UCR for the Health Investment Option is set at 70% of the range for the applicable geographic area where the service is being rendered. UHC uses Fair Health (Fairhealth.org).

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 deductible, copays, coinsurance and prescription copays. Separate out-of-pocket maximums apply to in-network and out-of-network benefits.

This summary describes key plan features. A chart with common medical events shows how these plan features apply when you have health care expenses.
# Fordham University Benefit Summary: Choice Plus Health Investment Option

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<th>Plan Feature</th>
<th>What It Is</th>
<th>How It Affects Your Plan Benefit</th>
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<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: when care is received in-network, most benefits are paid at 80% after you meet an annual deductible. There are no claim forms to file</td>
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<td></td>
<td></td>
<td>Out-of-Network: you pay a deductible and coinsurance. You may need to pay the expense up front and file a claim for reimbursement. You may also be balance billed for amounts over the usual, customary and reasonable charges</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 $750 (employee only coverage) or $1,500 (family coverage). This amount will be prorated for new hires. You may also contribute through pre-tax payroll deductions and/or make lump contributions.</td>
<td>The account is available only if you choose the Health Investment Option. You may use your HSA to pay in-network and out-of-network expenses</td>
</tr>
<tr>
<td>Annual deductible</td>
<td>An amount you pay each year before the plan begins to pay benefits. In a family, there is no individual level deductible; the family level deductible must be satisfied before the plan begins to pay benefits.</td>
<td>$1,600 employee only $3,200 family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$3,000 employee only $6,000 family</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>The percentage of costs you and the plan each pay, after you meet the deductible</td>
<td>After you meet the deductible, you pay 20% of the cost of care; the plan pays 80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>After you meet the deductible, you pay 40% of the cost of care; the plan pays 60%</td>
</tr>
</tbody>
</table>
### Copay
An amount you pay toward the cost of prescription drug expenses after you meet your deductible.

Prescription copay amounts vary depending on type of drug and whether the purchase is retail or mail order.

### Out-of-pocket maximum
An annual limit on the amount you spend for covered health care expenses; includes deductibles, copays and coinsurance. The plan pays 100% of additional covered expenses for the year if you reach your out-of-pocket maximum. In a family, there is no individual level out-of-pocket maximum; the family level out-of-pocket maximum must be satisfied before the plan pays 100% for the remainder of the calendar year.

<table>
<thead>
<tr>
<th></th>
<th>$3,000 employee only</th>
<th>$6,000 family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-pocket maximum</td>
<td>$6,000 employee only</td>
<td>$12,000 family</td>
</tr>
</tbody>
</table>

### Preventive care
Preventive care is covered in full, in-network. Coverage includes annual check-ups, lab tests and screenings based on age and gender.

Plan pays 100%.

You pay 40% after the deductible; plan pays 60%.
The chart that follows shows how benefits are paid, 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>
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<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>
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</table>
| You get a routine physical exam            | ▪ Physician’s office visit  
 ▪ 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) | No cost to you; plan pays 100% | You pay 40%, after the deductible; plan pays 60% | 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 [www.uhcpreventivecare.com](http://www.uhcpreventivecare.com) |
<p>| You need to see a doctor because of an illness or injury | ▪ Primary care office visits                                                                 | You pay 20%, after the deductible; plan pays 80% | You pay 40%, after the deductible; plan pays 60%                                                                                                           |
|                                             | ▪ Specialist and urgent care center visits                                             | You pay 20%, after the deductible; plan pays 80% | You pay 40%, after the deductible; plan pays 60%                                                                                                           |
|                                             | ▪ Outpatient diagnostic lab and x-ray tests                                           | You pay 20%, after the deductible; plan pays 80% | You pay 40%, after the deductible; plan pays 60%                                                                                                           |
|                                             | ▪ Scopic procedures*                                                                  | You pay 20%, after the deductible; plan pays 80% | You pay 40%, after the deductible; plan pays 60%                                                                                                           |
| You require emergency room care            | ▪ Ambulance transportation                                                             | You pay 20%, after the deductible; plan pays 80% | In- and out-of-network, pre-service notification is required for non-emergency ambulance                                                                       |
|                                             | ▪ Evaluation by hospital ER staff; related fees for diagnostic tests &amp; treatment       | You pay 20%, after the deductible; plan pays 80% | Out-of-network, pre-service notification is required if ER visit results in inpatient stay                                                                         |</p>
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| You are admitted to the hospital | ▪ Daily hospital room and board charges, services and supplies  
▪ Physician and hospital staff charges  
▪ Diagnostic lab and x-ray tests; scopic* procedures; CT, PET, and MRI scans; anesthesia; surgery; pharmaceutical and therapeutic treatments | You pay 20%, after the deductible; plan pays 80% | You pay 40%, after the deductible; plan pays 60% | Out-of-network, pre-service notification is required |
| You have outpatient surgery performed in a doctor’s office, ambulatory surgery center or outpatient facility | ▪ Physicians’ charges  
▪ Facility fees | You pay 20%, after the deductible; plan pays 80% | You pay 40%, after the deductible; plan pays 60% |  |
| You need hearing aids | ▪ Hearing exam with services as needed by ear, nose and throat specialist | You pay 20%, after the deductible; plan pays 80% | You pay 40%, after the deductible; plan pays 60% |  |
|                       | ▪ Hearing aid | You pay 20%, after the deductible; plan pays 80% | You pay 40%, after the deductible; plan pays 60% | Covers a single purchase (including repair/replacement) per hearing impaired ear once every three years |

*Scopic procedures are those required for visualization, biopsy and polyp removal, and include endoscopy, colonoscopy, and sigmoidoscopy.
### Common Medical Events

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| **You are pregnant**  | - Physician’s office visits  
                      - Screenings and lab work prescribed by your doctor  
                      - Hospital charges for labor, delivery and newborn care | You pay 20%, after the deductible; plan pays 80% | You pay 40%, after the deductible; plan pays 60% | Out-of-network, pre-service notification is required if an inpatient stay is longer than 48 hours after a normal vaginal delivery or 96 hours after a cesarean section delivery |
| **You undergo infertility treatment** | - New York state mandated benefits, including testing, prescription drugs, and high-level counseling  
                      - Services for the diagnosis and treatment of corrective medical conditions which result in fertility | You pay 20%, after the deductible; plan pays 80% | You pay 40%, after the deductible; plan pays 60% | Pre-service notification is required in- and out-of-network |
| **You require mental health or substance abuse treatment** | - Inpatient care  
                      - Outpatient care | You pay 20%, after the deductible; plan pays 80% | You pay 40%, after the deductible; plan pays 60% | Pre-service notification is required out-of-network |
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<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</td>
</tr>
<tr>
<td></td>
<td>▪ Treatments such as dialysis, IV chemotherapy or other IV infusion therapy, radiation oncology</td>
<td></td>
<td></td>
<td>Pre-service notification is required out-of-network for chiropractic care</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>Pre-service notification is required out-of-network</td>
</tr>
<tr>
<td></td>
<td>▪ Home health 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</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 out-of-network for inpatient stays</td>
</tr>
<tr>
<td>Common Medical Events</td>
<td>Services You May Need</td>
<td>If You Stay In-Network</td>
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<tr>
<td>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 exam only, once every two years. Separate vision care coverage is available through VSP.</td>
</tr>
</tbody>
</table>
Additional Covered Expenses
Coverage for many conditions 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
- Treatment of diabetes and related conditions
- Obesity surgery
- Reconstructive procedures
- Temporomandibular Joint Services

Neurobiological and 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-network services must be received at a designated transplant facility.
- 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 do not require a deductible or coinsurance. Copays 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
Express Scripts (ESI) has an extensive network of pharmacy partner—from major chains and supermarkets to neighborhood pharmacists. ESI 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 ESI’s negotiated cost and the amount charged by the out-of-network pharmacy.

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
Plan Exclusions
Aside from preventive care, the Choice Plus Health Investment 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. Your plan document has complete details about covered services and supplies, limitations and conditions, and exclusions.

- Dental care, unless it is related to an accidental injury or disease
- 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 - there is a discount program available through UHC
- Health services and supplies that are not deemed to be medically necessary

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 Health Investment Option. Key features of the HSA include:

- The University contributes $750 (employee only coverage) or $1,500 (family coverage) as long as you open an HSA account with Discovery Benefits.
- You may contribute to the HSA through pre-tax payroll deductions and/or make post-tax 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.
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 may have a limited purpose FSA which reimburses for dental and vision expenses only.
- 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.

Opening an HSA
Wex provides HSA banking services to all individuals who choose the Health Investment Option. Activating your HSA through Wex is a simple process. If you don’t activate 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 activated your HSA. Contributions are pro-rated for individuals who are not covered under the Health Investment 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:

Pre-Tax
- Payroll contributions
- A rollover of funds from another HSA if you have one

Post-Tax
- Electronic transfers from another bank account
- A personal check—from you or someone contributing on your behalf

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 2024:

<table>
<thead>
<tr>
<th>HSA Coverage Level</th>
<th>2024 HSA Contribution Limit</th>
<th>Fordham’s Contribution</th>
<th>Your Maximum 2024 Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$4,150</td>
<td>$750</td>
<td>$3,400</td>
</tr>
<tr>
<td>Family</td>
<td>$8,300</td>
<td>$1,500</td>
<td>$6,800</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 the HSA debit card for eligible expenses wherever Visa® is accepted.

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 pay the expense with after-tax dollars. Once funds are back in your account, you can request a reimbursement to cover all or part of the expense. 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 on IRS.gov/publications.