2025 BENEFITS GUIDE

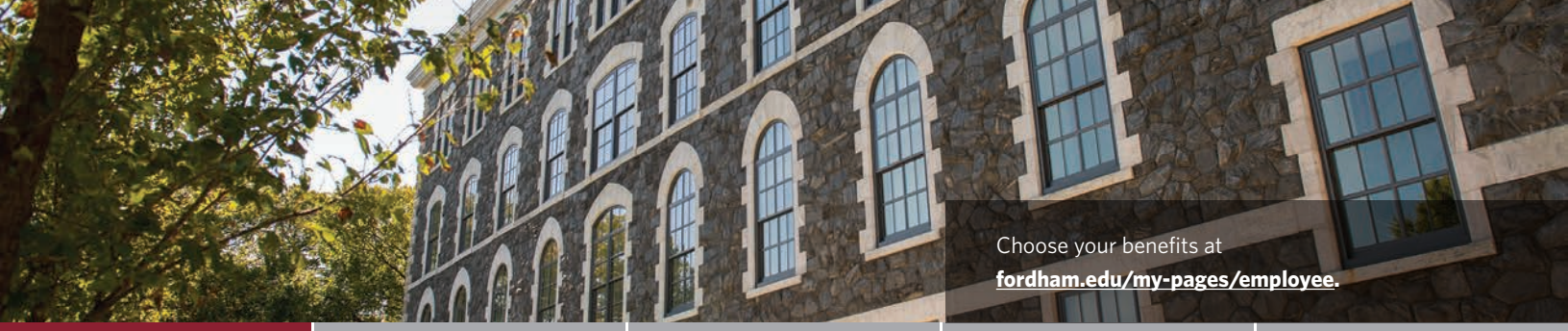
Clerical Employees of Local 153

MY FORDHAM BENEFITS

HEALTH | RETIREMENT | LIFE

FORDHAM UNIVERSITY

THE JESUIT UNIVERSITY OF NEW YORK



This Enrollment Guide is clickable. If you're viewing the guide online, you can click on a link to go directly to the information you need or scroll through the document page by page. You can also print the entire guide or sections of it by choosing a page range.

Welcome to Your Fordham Benefits

Fordham University is committed to the physical, emotional, and financial health of its faculty, administrators, and staff. 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 select from:

- Two medical plan options with prescription drug coverage
- Three dental plan options
- Two vision plan options
- Health Care, Limited Purpose and Dependent Care Flexible Spending Accounts (FSAs)
- Retirement Benefits
- Supplemental Life Insurance benefits

The University also provides several Other Benefits:

- Employee Assistance Program (EAP)
- MSK Direct
- Identity Theft Protection
- Long-term Disability
- Basic Life and AD&D Insurance
- Travel Assistance Resources
- Savi for Student Loans
- Virtual Physical Therapy
- UHC Personal Health Nurse
- Calm Health
- One Pass Select
- Maven Maternity

The University community will also benefit from MyAdvocate, 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 Other 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 27 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, or email Benefits@Fordham.edu.

ITEMS TO CONSIDER FOR 2025

For Current Benefits-Eligible Faculty and Administrators

Open Enrollment begins **October 28 and ends November 8, 2024.** It's your annual opportunity to make benefit selections that are best for your needs.

Take the Opportunity to Review Your Benefits
Your 2024 benefits will roll over into 2025 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 90 days to enroll in your benefits from the date you become eligible. 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"
  - "Flexible Spending Accounts"
- User guides for the Health Investment Option and Enhanced Standard Option to help you make the most of your coverage throughout the year.

ELIGIBILITY AND ENROLLMENT

Enrolling for Coverage

- Things to Consider
- Online Enrollment
- Waiving Coverage

Changing Your Choices

Who's Eligible for Benefits

Covering Your Dependents

Eligibility and Enrollment

ENROLLING FOR COVERAGE

Open Enrollment begins **October 28 and ends November 8, 2024.**

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.

Benefitexpress, the Online Enrollment System

With the University's online enrollment system, you can log on to the system through fordham.edu/my-pages/employee.

- Under "Human Resources", select "My Fordham Benefits" and then click the "Benefitexpress" button.
- 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.

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WAIVING COVERAGE

You must actively waive coverage for 2025 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. You can use this stipend to find coverage elsewhere, if you choose

The stipends will begin with the first payroll in 2025 and continue through December 31, 2025. 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
- Change in employment category

Any benefit change you request must coincide directly with your family status change and must be completed on Benefitexpress, with proof of the family status change, within 30 days of the change.

Each time you are finished with a screen, click the green **Continue** tab in the bottom-left corner of the screen to move forward. As you consider different choices along the way, you can click on the **Recalculate** tab to see the effect a given choice will have on your total cost.

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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, dental, and vision 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

The Plan reserves the right to request verification of dependent status at any time and will pursue any fraudulent activity, which may result in disciplinary action, including repayment of claims paid on ineligible dependents dating back to original enrollment and/or termination of employment.

Your Fordham Benefit Options

YOUR BENEFIT OPTIONS

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Remember, both options pay the full cost of in-network preventive care.

MEDICAL PLAN

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 by 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:

- Out-of-network charges reimbursed at the 90th percentile of usual, customary, and reasonable charges.

Infertility Coverage

Both options will include coverage for fertility services related to the diagnosis and treatment of infertility, including ovulation induction and in vitro fertilization. The plans also include coverage for fertility preservation services when a medical treatment such as surgery, radiation or chemotherapy will lead to infertility.

Tools and Resources

- 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"
  - "Flexible Spending Accounts"

The chart on page 14 shows several plan features and how you share in the cost of care.

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You might be wondering...	Fordham University Medical Plan – Two Options	
	Health Investment Option	**Enhanced Standard Option**
Does the plan cover both in- and out-of-network providers?	Yes*	Yes*
Is there an in-network deductible?	Yes	Yes
Will I pay more for coverage or more for care?	Care (when you pay for services)	Coverage (through payroll deductions)
Is preventive care free to me?	Yes, in-network	
Will I pay a fixed copay or coinsurance** for non-preventive care in-network?	Coinsurance	Copay or coinsurance, depending on the type of expense
What is my limit for out-of-pocket expenses?	**In-network:** $3,000 employee-only $6,000 family **Out-of-network:** $6,000 employee-only $12,000 family	**In-network:** $2,500 employee-only $5,000 family **Out-of-network:** $2,500 employee-only $5,000 family
What type of accounts can I use to pay eligible expenses tax-free?	Health Savings Account Limited Purpose Flexible Spending Account	Health Reimbursement Account Health Care Flexible Spending Account
What makes this option special?	An increasingly popular plan option Features a tax-free HSA with contributions from the University and plan participants Encourages long-term planning and saving for health expenses	Very low out-of-pocket costs

** 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.

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On the following pages, take a closer look at the key elements that differentiate your plan options. 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 $1,650 employee-only/$3,300 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.

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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 WEX. 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 2025:

HSA Coverage Level	2025 HSA Contribution Limit	Fordham's Contribution	Your Maximum 2025 Contribution
Employee-only	$4,300	$750	$3,550
Family	$8,550	$1,500	$7,050

The University will make its full contribution to your HSA on January 1, 2025, 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 2025, 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 have 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.

Use Your Health Care FSA Funds by December 31, 2024

In order to contribute to your HSA and receive contributions from the University beginning January 1, 2025, **you must have a zero dollar balance in your Health Care FSA by December 31, 2024**. Otherwise, you will not be able to make or receive contributions until April 1, 2025. This is a special rule imposed by the IRS.

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Activating Your HSA

When you enroll in the Health Investment Option for the first time, you will be able to activate an HSA through WEX. 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.

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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 outpatient rehabilitative services.

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.
- **Account expense rollover (limited).** Please make sure that any eligible expenses are filed on or prior to 3/31/2026.
- **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 19 to learn more.

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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 94.7% 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 2024. So, if you were seeing a UHC Choice Plus doctor in 2024, you'll most likely be able to continue seeing your provider in 2025.

If you are currently enrolled in a medical plan option through the University, visit 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, 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) 314-0335** if you are in the Health Investment Option or **(866) 633-2446** 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 26.

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Both the Health Investment Option and the Enhanced Standard Option provide coverage for hearing aids. Benefits include a single purchase, including repair and replacement, per hearing-impaired ear every three years.

Fordham University Medical Plan Options

	Health Investment		Enhanced Standard	
Plan Feature	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Tax-Advantaged Account				
Account type	Health Savings Account (HSA)		Health Reimbursement Account (HRA)	
Fordham contributions	Employee-only: $750 Family: $1,500		Employee-only:$400 Family: $800	
Your contributions	See page 10 for how much you can contribute		Not permitted	
Annual Deductible				
Employee-only	$1,650	$3,300	$250	$300
Family	$3,300	$6,600	$500	$600
Annual Out-of-Pocket Maximum				
Employee-only	$3,000	$6,000	$2,500	$2,500
Family	$6,000	$12,000	$5,000	$5,000
Coinsurance and Copays				
Preventive Care	No cost to you	You pay 40% after deductible	No cost to you	You pay 20% after deductible
Office Visit: PCP and Specialist	You pay 20% after deductible	You pay 40% after deductible	Primary care, Chiropractic or Occupational Therapy: $25 copay Specialist: $50 copay	You pay 20% after deductible
Emergency Room		You pay 20% after deductible	$100 copay	$100 copay
Outpatient Diagnostic Testing		You pay 40% after deductible	Minor diagnostics and X-ray: You pay 5% after deductible Major diagnostics (e.g., CT, PET, MRI): $250 copay Lab services: You pay 5% after deductible	You pay 20% after deductible
Hospital Inpatient Care		You pay 40% after deductible	$250 copay	You pay 20% after deductible
Most Other Covered Services		You pay 40% after deductible	You pay 5% after deductible	You pay 20% after deductible

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Use a Network Pharmacy to Get Maximum Value

How Are Tiers Determined?

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PRESCRIPTION DRUGS

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

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 all 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.

- 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 all 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.

Prescription Drug Copay Amounts by Option				
	Health Investment*		Enhanced Standard	
Prescription Drug Category	**Retail 30-day Max**	**Mail Order 90-day Max**	**Retail 30-day Max**	**Mail Order 90-day Max**
Tier 1	$10	$25	$10	$20
Tier 2	$35	$87.50	$25	$50
Tier 3	$60	$150	$50	$100

** 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

Express Scripts is Fordham's pharmacy vendor for prescription drugs. Express Scripts Inc (ESI) has an extensive network of pharmacy partners—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.

YOUR BENEFIT OPTIONS

Medical Plan

Prescription Drugs

- Use a Network Pharmacy to Get Maximum Value
- **How Are Tiers Determined?**

Dental Plan

Vision Plan

Flexible Spending Accounts (FSAs)

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How Are Tiers Determined?

ESI 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 ESI 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

Tier 2: Nexletol

Tier 3: Zocor

Explore Express Scripts resources!

https://www.express-scripts.com/.

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DENTAL PLAN

The University offers two dental options, both administered by Cigna. Your choices are:

- A Dental Health Maintenance Organization (DHMO), which pays benefits only when you receive care within the Cigna DHMO network.
- A Dental Preferred Provider Organization (DPPO), which pays a higher share of the cost when you receive care from providers in the Cigna dental network, but you still have the choice to go in- or out-of network for care.
- The Buy Up Dental Preffered Provider Organization (DPPO), is your richest dental plan option. This plan pays a higher share of the cost than the DPPO when you receive care from providers in the Cigna dental network, but you still have the choice to go in- or out-of-network for care.

To find participating dental care providers, go to http://hcpdirectory.cigna.com.

The following chart shows **your share of the cost** for common covered expenses under all dental options.

	DHMO		DPPO		BUY UP DPPO	
Service/Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network***	**In-Network**	**Out-of-Network***
Annual Deductible	None	Plan does not provide out-of-network benefits	$50 per person; $150 per family		$50 per person; $150 per family	
Preventive and Diagnostic Care	No cost to you for preventive/ diagnostic care and basic fillings;		No cost to you	You pay 20% after deductible	No cost to you	
Basic Restorative Care	You share the cost of services based on Cigna's Dental Patient Charge Schedule**		You pay 20% after deductible	You pay 40% after deductible	No cost to you	No cost to you
Major Restorative Care			You pay 50% after deductible	You pay 50% after deductible	You pay 40% after deductible	You pay 40% after deductible
Orthodontia			You pay 50%, no deductible; plan pays up to $1,500 lifetime maximum for orthodontia		You pay 40%, no deductible; plan pays up to $2,500 lifetime maximum for orthodontia	
Calendar Year Maximum	No maximum plan benefit		Plan pays up to $1,500 per person		Plan pays up to $2,500 per person	

** You are also responsible for paying any difference in cost between the out-of-network provider's charge and Cigna's Maximum Allowable Charge for the service.*

*** 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.*

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VISION PLAN

Through Vision Service Plan (VSP), the University's Vision Plan offers two options to help pay the cost of routine eye care and eyewear. Both options pay a higher share of the cost when you use providers in the VSP network. To find participating vision care providers, go to https://www.vsp.com/find-eye-doctors.html.

The following chart shows how **you and the plan share the cost** for common covered expenses under both vision options.

	Base Option		Premier Option	
Service	**Benefit**	**Frequency**	**Benefit**	**Frequency**
Well Vision Exam	$5 copay	Every year	$5 copay	Every year
Prescription Glasses	$10 copay		$10 copay	
Lenses (single vision, lined bifocal, and lined trifocal)	No copay (included in copay for prescription glasses)		No copay (included in copay for prescription glasses)	
Frames	• $170 allowance for a wide selection of frames • $190 allowance for featured frame brands • $95 allowance at Costco • 20% savings on the amount over your allowance	Every other year	• $220 allowance for a wide selection of frames • $240 allowance for featured frame brands • $120 allowance at Costco • 20% savings on the amount over your allowance	Every year
Contacts (instead of glasses)	• $170 allowance for contacts • Up to a $60 copay for fitting and evaluation • Contact lens exam included	Every year	• $220 allowance for contacts • Up to a $60 copay for fitting and evaluation • Contact lens exam included	Every year

Out-of-Network Benefits

If you go to a provider outside the VSP network, VSP will provide an allowance based on the following schedule:

- Exam: up to $45
- Frame: up to $70
- Single-Vision Lenses: up to $30
- Lined Bifocal Lenses: up to $50
- Lined Trifocal Lenses: up to $65
- Progressive Lenses: up to $50
- Contacts: up to $105

Out-of-network providers typically charge more than in-network providers. In addition, if you use an out-of-network provider, you must pay the bill and then request reimbursement.

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- **Health Care FSA**
- **Limited Purpose FSA**
- Dependent Care FSA
- IRS Guidelines for FSAs
- Retirement Benefit

FLEXIBLE SPENDING ACCOUNTS (FSAS)

If you want to participate in a Flexible Spending Account (FSA), you must make a contribution election every year on Benefitexpress. **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 $3,200 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.

Note: FSA contributions are based on current 2024 contribution limits and are subject to IRS changes.

Section continued on next page >

Individuals who choose the Health Investment Option are not eligible to participate in the Health Care FSA. However, they may contribute to a Limited Purpose FSA.

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

- As of 2024, you may contribute up to $3,200 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 under age 13 or for an elderly or disabled dependent who relies on you for support. If your child turns 13 during the year, only expenses for the time the child was under age 13 will be eligible for the Dependent Care FSA.
- 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.

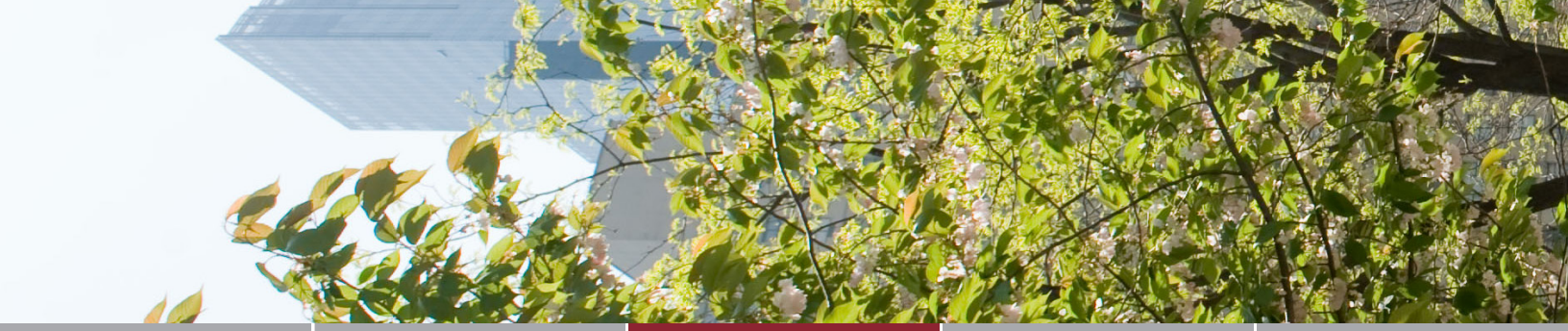
IRS Guidelines for Health Care, Limited Purpose, and Dependent Care FSAs

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 irs.gov/forms-pubs/about-publication-969.

Note: FSA contributions are based on current 2024 contribution limits and are subject to IRS changes.



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RETIREMENT BENEFIT

Local 153 Clerical Participants

Fordham University Local 153 employees are not required to contribute to the Retirement Plan. However, when you reach 2 years of service, Fordham will automatically contribute 5% of your biweekly salary into the Fordham Retirement Plan account. After 3 years of service, the University will contribute 5.25% of your biweekly salary and when you reach 5 years of service, the University will contribute a total of 6.25% of your biweekly salary to the Fordham Retirement Plan. Please refer to the chart below explaining the contribution schedule.

In addition, upon reaching 2 years of service, Local 153 employees, can elect to make elective deferral contributions to the Fordham Retirement Plan in order to receive an additional University matching contribution. Local 153 employees can voluntarily contribute a percentage from from .50% to 1.750% of their biweekly salary in order to receive an additional matching University contribution. These matching contributions are in addition to the basic University contribution you automatically receive for years of service. Please refer to the chart below explaining the contribution schedule.

You can begin your Retirement Plan contributions via Retirement@Work, which is located in Fordham's employee portal - fordham.edu/my-pages/employee. The Retirement Plan offers two investment providers, TIAA and Fidelity Investments. You can initiate your enrollment via Retirement@Work and once enrolled you can access your account through Retirement@Work or through your investment provider's account websites: TIAA (www.tiaa.org) and Fidelity Investments (www.netbenefits.com). Fordham's default provider for university contributions is TIAA and you can change your investment provider to Fidelity through Retirement@Work.

Fordham Local 153 Clerical employees can also elect to make Voluntary contributions in addition to the matching contributions at any time up to the IRS Voluntary Maximum contribution limit.

Please refer to the Local Union 153 Clerical contract for more detailed information on the Retirement Plan benefits.

Automatic Employer Contributions

Years of Service	University Contributions
0 - 2 Years	0
2+ Years	5%
3+ Years	5.25%
5+ Years	6.25%

Additional Voluntary & Matching Contributions

Years of Service	Employee Elective Deferral	University Matching Contribution
2+ Years on 7/1/2021	0.5% or 1% or 1.25%	0.5% or 1% or 1.25%
2+ Years on 7/1/2022	0.5% or 1% or 1.25% or 1.5%	0.5% or 1% or 1.25% or 1.5%
2+ Years on 7/1/2023	0.5% or 1% or 1.25% or 1.50% or 1.75%	0.5% or 1% or 1.25% or 1.50% or 1.75%

Other Benefits

- **MyAdvocate**
- **Employee Assistance Program (EAP)**
- **MSK Direct**
- **Identity Theft Protection**
- Long-Term Disability
- Life/Accidental Death & Dismemberment (AD&D)
- 24-Hour Travel Assistance
- Savi
- Virtual Physical Therapy
- UHC Personal Health Nurse
- Calm Health
- One Pass Select
- Maven Maternity

Other 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.

MyAdvocate

MyAdvocate 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 MyAdvocate 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 TELUS mobile app, and by phone 24 hours a day, seven days a week. Log in to the EAP website to learn more (**Login:** Metlifeeap **Password:** eap).

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
- Identity theft recovery and more

Your program includes up to five phone or video consultations with licensed counselors for you and your eligible household members, per issue, per calendar year. The program also offers easy-to-use educational tools and resources. You don't need to be covered under the University's health care plans to use the EAP.

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.

MSK Direct

If you are facing cancer, it's critical to feel confident about getting the right diagnosis and treatment. Fordham University has partnered with Memorial Sloan Kettering Cancer Center (MSK), the Northeast's top-ranked cancer hospital, to offer MSK Direct. You can take advantage of this employee benefit to get guided access and expert cancer care, as well as practical and emotional support, for yourself and your family members.

You will work with an experienced and compassionate team of Memorial Sloan Kettering Cancer Center nurses, social workers, and Care Advisors to connect with expert care along with the practical and emotional support you need to help see you through.

Once you contact MSK Direct, you can get an appointment scheduled usually within two business days. For your convenience, you can visit any MSK facility, in Manhattan, Brooklyn, Westchester, New Jersey and on Long Island. Of course, the decision on where to go for care is always yours to make.

Your pay nothing more than your insurance plan's standard copays, coinsurance, and deductibles for MSK medical services. Contact your health plan to determine your coverage.

To contact MSK Direct, call a Care Advisor toll-free, **(844) 506-0589**, Monday through Friday from 8:30 a.m. to 5:30 p.m. Eastern Time. Messages left outside these hours will be returned the next business day.

Identity Theft Protection

Identity theft is the fastest-growing crime in the U.S. With Identity Theft coverage, you have access to Identity Theft solution services administered by AXA Assistance USA, Inc. You can receive an ID theft risk and prevention toolkit and resolution guide. AXA will also help with filing and obtaining police and credit reports, and contacting creditor fraud departments. Learn more by visiting the AXA website (**Login:** axa **Password:** travelassist)

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- **Life/Accidental Death & Dismemberment (AD&D)**
- **24-Hour Travel Assistance**
- Savi
- Virtual Physical Therapy
- UHC Personal Health
- Nurse
- Calm Health
- One Pass Select
- Maven Maternity

Long-Term Disability

Long-term Disability (LTD) pays 60 percent of basic monthly earnings if an illness or injury keeps you from working for an extended period of time. The maximum monthly benefit is $6,000. LTD benefits will be paid to you tax-free since the cost of the premium, although paid by Fordham, is considered part of your taxable income. In most cases, LTD benefits become payable after six months of disability and continue for as long as you remain disabled, to age 65.

Life/Accidental Death & Dismemberment (AD&D) Insurance

The Basic Life and AD&D Insurance plans through MetLife provide a basic level of protection if you work 25 hours or more each week. The Basic Life Insurance plan provides a benefit to your beneficiary upon your death. Basic AD&D provides a lump sum benefit if you die or are seriously injured as the result of an accident. AD&D coverage for loss of life is equal to your Basic Life Insurance coverage.

Your basic benefit amount is $10,000

24-Hour Travel Assistance

Whether traveling internationally or domestically, you and your dependents can access professional medical, travel, legal, financial and concierge services, 24 hours a day, 365 days a year. AXA Assistance USA, Inc. 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, you can also receive assistance with restaurant, shopping, hotel and airline recommendations and reservations, entertainment referrals, driving directions and more. Physician, hospital or dental referrals, along with virtual consultations with a U.S. medical care provider while traveling abroad, are also available as part of your Travel Assistance benefit. Learn more by visiting the AXA website.

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Calm Health

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Savi

Reducing your monthly student loan payment and working toward loan forgiveness could be getting much easier. You and your family members have access to Savi, a robust tool that helps you find the best federal repayment and forgiveness programs for your financial situation. Borrowers working with Savi can save an average of $187 on their student loan payments!

Fordham covers the cost of Savi Essential for employees! With this premium Savi plan, they can help you:

- Help identify ways you can save money on your monthly payments
- Create a clear path to apply for student loan forgiveness programs
- Provide answers to all of your student loan questions through educational webinars and customized support
- Keep you updated on new programs and policy changes
- Removes the complexities of forgiveness programs and does the heavy lifting of digitizing and filing your paperwork

Get started today at tiaa.org/fordham/student

Virtual Physical Therapy

Start your journey to living pain free with Sword, digital physical therapy for back, joint and muscle pain that you can do from the comfort of your home, or anywhere. Best of all, with Sword no referral is needed, there's no copay so it's free to eligible members as part of your health plan benefits. Please learn more at https://meet.swordhealth.com/fordhamuniversity or call 1-888-492-1860.

Thrive

Digital Physical Therapy that combines licensed physical therapists with easy to use technology. Thrive is more than just convenient, 67% of members are pain-free by the end of their first program.

Bloom

Sword Health developed Bloom to give relief from pelvic health disorders with an easy-to-use, at-home pelvic therapy solution. Bloom covers all life stages and 64% of women reported significant improvement after the program.

Move

Move connects members with a Physical Health Specialist to deliver a weekly, personalized movement plan designed to keep members moving whilst avoiding MSK pain.

UHC Personal Health Nurse

Imagine if there was ... ONE person who answers all your benefit and health care questions, and helps you get more out of your company benefits.

ONE person who has your best interests at heart, and ensures you and your family always get the best care available.

ONE person who listens and understands what's important to you.

That's the power of ONE.

That's the power of your Personal Health Nurse.

This 100% confidential and FREE service through UnitedHealthcare is personalized to make a real difference in the quality of care you receive. Call the number on the back of your member ID card and ask for a Personal Health Nurse or visit www.myuhc.com to discover how the power of ONE will change your life!

Calm Heath

Calm Health is a new well-being app that builds on the self-guided content available from Calm (sleep, meditation and mindfulness) and includes additional features and resources for UnitedHealthcare members, including mental health screenings and recommendations to additional in-network solutions such as coaching and therapy.

One Pass Select

One Pass Select is a subscription-based fitness and well-being program for UnitedHealthcare members that supports a healthier lifestyle. Employees can access thousands of gym locations, including national brands and digital fitness options, with no long-term contracts or gym registration fees.

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- 24-Hour Travel Assistance
- Savi
- Virtual Physical Therapy
- UHC Personal Health Nurse
- Calm Health
- One Pass Select
- **Maven Maternity**

Maven Maternity

Maven is a 24/7 virtual support platform for UnitedHealthcare members that provides education and coaching, personalized guidance, and trustworthy resources for pregnancy and postpartum. With Maven, participants can book virtual appointments or message with providers spanning over 30 specialties, including OB-GYNs, doulas and lactation consultants.

Participants can also join drop-in groups, read articles related to pregnancy, and take ondemand classes, like pregnancy 101 and Infant CPR. A dedicated care advocate is a constant source of support throughout the maternity journey helping people understand, navigate, and engage with their benefits and their healthcare.

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.
- Resources such as a registered nurse. Review the toll free numbers on your 2025 ID card for details.
- Resources to help you find a doctor if you are currently enrolled. If you are not currently enrolled, you can still find a doctor here.
- An enhanced provider and cost estimator tool to help compare and estimate costs. Simply log in and access the tools you need.
- 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.

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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) 314-0335** for the Health Investment Option and **(866) 633-2446** for the Enhanced Standard Option.

Medical event	Health Investment Option	Enhanced Standard Option
Congenital Heart Disease Surgery	Required	Required
Congenital Disease and Anomaly	Required	Required
Clinical Trials	Required	Required
Dental Services – Accidental Injury	Required	Required
Dialysis	Required only for out-of-network	Required only for out-of-network
Emergency Room Care		
• Ambulance Transportation	Required for non-emergency ambulance	Required for non-emergency ambulance
• Evaluation by Hospital ER Staff; Related Fees for Diagnostic Tests and Treatment	Required if ER visit results in inpatient stay, only for out-of-network	Required if ER visit results in inpatient stay, only for out-of-network
Infertility Treatment	Required	Required
Hospital Admittance	Required only for out-of-network	Required only for out-of-network
Mental Health or Substance Abuse Treatment (Inpatient and Outpatient)	Required only for out-of-network	Required only for out-of-network
Obesity Surgery	Required	Required
Pregnancy	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	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
Reconstructive Procedures	Required only for out-of-network	Required only for out-of-network
Rehabilitative Services (Outpatient)	Required for chiropractic care only for out-of-network	Required for chiropractic care only for out-of-network
Special Treatment, Equipment, or Care in an Alternative Medical Setting		
• Durable Medical Equipment Over $1,000	Required only for out-of-network	Required only for out-of-network
• Home Health Care	Required only for out-of-network	Required only for out-of-network
• Hospice Care	Required only for inpatient stays out-of-network	Required only for inpatient stays out-of-network
• Skilled Nursing and Inpatient Rehabilitation Facility	Required only for out-of-network	Required only for out-of-network
Temporomandibular Joint (TMJ)	Required only for out-of-network	Required only for out-of-network
Transplants	Required	Required

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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 in-network and out-of-network deductibles. 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.**

Dental Preferred Provider Organization (DPPO): Works the same ways as the medical PPO. Benefit levels are highest when your dental care is delivered in-network. Reduced out-of-network benefits are available.

Evidence of insurability (EOI): Proof of good health, typically required for certain Life Insurance choices. Requires completion of a health statement and possibly a physical exam.

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 use your 2024 HRA for expenses incurred from January 1, 2024 through March 15, 2025, however you must submit claims by March 30, 2025.

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.

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VENDOR CONTACTS

During the Open Enrollment period, if you have any questions about your benefits, you may contact the 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.

Benefit/Plan	Vendor/Resource	Website	Telephone
Medical Options	UnitedHealthcare	myuhc.com	**For the Health Investment Option:** (866) 314-0335 **For the Enhanced Standard Option:** (866) 633-2446
Prescription Drugs	Express Scripts	www.express-scripts.com/NPFNPV9	(800) 939-3721
Dental	Cigna	cigna.com	(800) 244-6224
Vision	Vision Service Plan (VSP)	vsp.com	(800) 877-7195
Health Reimbursement Account	WEX	benefitslogin.wexhealth.com	(866) 451-3399
Health Savings Account			
Flexible Spending Accounts			
Retirement Benefit	TIAA Fidelity	www.tiaa.org www.netbenefits.com	TIAA: 800-842-2776 Fidelity: 800-343-0860
Long Term Disability	MetLife	metlife.com/mybenefits	(888) 762-2347
MSK Direct	Memorial Sloan Kettering - Cancer Center	N/A	(844) 506-0589
Life Insurance	MetLife	N/A	(800) 638-6420
Identity Theft Protection and 24-Hour Travel Assistance	MetLife/AXA Assistance, USA Inc.	metlife.com/travelassist	**In the U.S.** (800) 454-3679 **Worldwide, call collect** (312) 935-3783
Employee Assistance Program	MetLife/TELUS	metlifeeap.lifeworks.com **Login:** Metlifeeap **Password:** eap	(888) 319-7819
Virtual Physical Therapy	Sword	https://meet.swordhealth.com/fordhamuniversity	(888) 492-1860
Advocacy Services	MyAdvocate	MyAdvocateServices.com	(833) 968-1775
Student Loan Savings	Savi	tiaa.org/fordham/student	N/A

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LEGAL NOTICES

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or 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, using funds from their Medicaid or CHIP programs. 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 and you live in a State listed below, 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.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within **60 days of being determined eligible for premium assistance**. 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)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/healthinsurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-programreauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2

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U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740. TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711 | Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website:
https://mn.gov/dhw/health-care-coverage/
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218 | Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
Toll free number for the HIPP program: 1-800-852-3345, ext 15218

NEW JERSEY – Medicaid and CHIP

Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-800-356-1561 CHIP Premium Assistance
Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742 or 1-866-614-6005

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

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TEXAS – Medicaid

Website: http://hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)
Website: https://medicaid.utah.gov/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/

VERMONT– Medicaid

Website: dvha.vermont.gov/members/medicaid/hipp
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://www.coverva.dmas.virgina.gov/learn/premiumassistance/famis-select
https://www.coverva.dmas.virgina.gov/learn/premiumassistance/health-insurance-premium-paymenthipp-programs
Medicaid / CHIP Phone: 1-800-432-5924 | 1-800-522-5582
TDD: 1-888-221-1590

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid

Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1629

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration

www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Creditable Prescription Drug Coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Fordham University medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2025. This is known as "creditable coverage."

Why this is important: If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2025 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

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..

Please read the notice below carefully. It has information about prescription drug coverage with Fordham University and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

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Notice of creditable coverage

You may have heard about Medicare's prescription drug coverage (called Part D),and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the Fordham University prescription drug plans, you'll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2025. This is called creditable coverage. Coverage under one of these 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.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the Fordham University plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Fordham University coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment or other qualifying event, or otherwise become newly eligible to enroll in the Fordham University plan mid-year, assuming you remain eligible.

You should know that if you waive or leave coverage with Fordham University and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this Fordham University coverage changes, or upon your request. For more information about your options under Medicare prescription drug coverage More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number) or visit the program online at https://www.shiptacenter.org/.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For More information about this notice or your prescription drug coverage, contact the benefits team.

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For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call (800) 772-1213 (TTY (800) 325-0778).

The Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

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Newborns' and Mothers' Health Protection Act notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours if applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

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.

HIPAA Special Enrollment Notice

As you know, if you have declined enrollment in the University health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

The University will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of [30/31] – from the date of the Medicaid/CHIP eligibility change to request enrollment in the University's group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Summary of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the The Fordham University Medical Plan 2025 summary plan description (SPD). It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

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HIPAA Privacy Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans on the use and disclosure of individual health information by Fordham University Health Plans. 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. This notice describes the privacy practices of these plans: Medical, Pharmacy, EAP, health FSA, and HRA. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

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 Fordham University programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

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. Here are some examples of what that might entail:

- Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- Payment includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- Health care operations include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

How the Plan may share your health information with Fordham University

The Plan, or its health insurer, may disclose your health information without your written authorization to the University for Plan administration purposes. The University may need your health information to administer benefits under the Plan. 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.

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Here's how additional information may be shared between the Plan and Fordham University, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to Fordham University, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to Fordham University information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Fordham University cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Fordham University from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

- Workers' Compensation - Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
- Necessary to prevent serious threat to health or safety - Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
- Public Health Activities - Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
- Victims of abuse, neglect, or domestic violence - Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)

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- Judicial and Administrative Proceedings - Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
- Law Enforcement Purposes - Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
- Decedents - Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
- Organ, eye, or tissue donation - Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
- Research purposes - Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
- Health Oversight Activities - Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
- Specialized government functions - Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
- HHS Investigations - Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

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The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

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Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

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Right to obtain a paper copy of this notice from the Plan upon request
You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice
The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2025. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice over e-mail.

Complaints
If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, reach out to the benefits team.

Contact
For more information on the Plan's privacy policies or your rights under HIPAA, contact the benefits team.