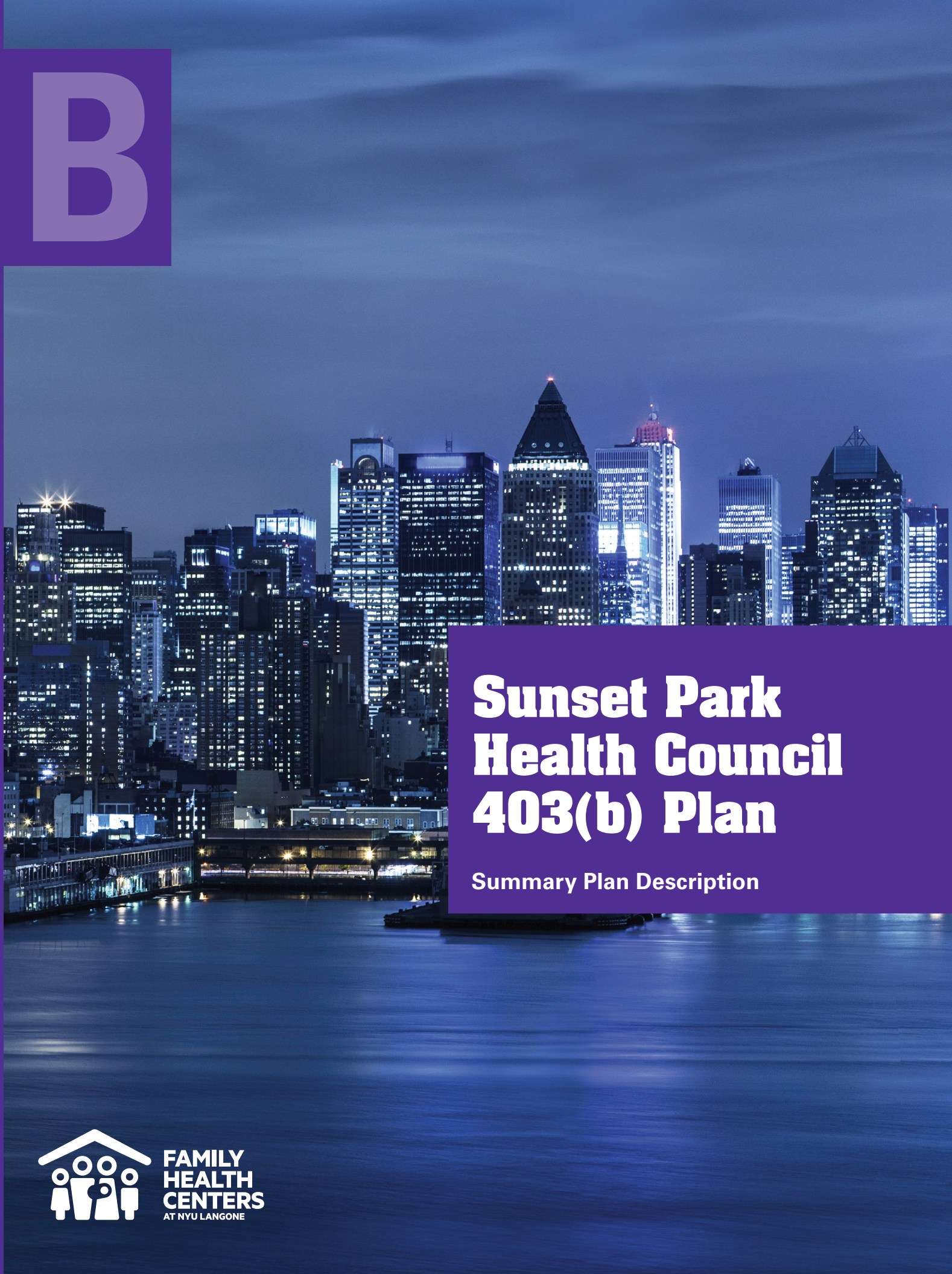

Sunset Park Health Council 403(b) Plan

Summary Plan Description

FAMILY HEALTH CENTERS
AT NYU LANGONE

This booklet summarizes the provisions contained in the legal plan documents for the Sunset Park Health Council 403(b) Plan (the "Plan"). The official plan documents will govern in the event of any conflict with the terms of this booklet. The plan documents are available for you to read; to obtain a copy, contact the NYU Langone Health Human Resources Department at **212-404-3787** or via email at **NYULMCBenefits@nyulangone.org**. Sunset Park Health Council reserves the right to discontinue or change the Plan at any time. Nothing in this Summary Plan Description should be interpreted as implying a contract of employment. Being a participant in the Plan does not imply any right of continued employment with Sunset Park Health Council.

The issue date of this booklet is January 2022.

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SAVING FOR YOUR FUTURE

Overview

One of the chief benefits of being a Sunset Park Health Council employee is the opportunity to participate in the Plan. This Plan is a tax-deferred 403(b) retirement plan to which Sunset Park Health Council contributes and you have the option to contribute.

Sunset Park Health Council employees have a benefit plan that gives them a powerful start on retirement savings: If you are eligible, Sunset Park Health Council contributes 6% of your eligible salary without any required contribution on your part. You can supplement this with tax-deferred savings from your paycheck.

You can decide whether you want to manage your own investment portfolio from a menu of fund options or you can select mutual funds which automatically rebalance each year to your target retirement date. Or, if you don't make a selection, contributions will be invested in the Plan's default investment fund until you direct otherwise.

If you are not already saving from your salary, you may think it will be impossible to start. But the Plan makes it easy: Your contribution comes out of your salary before you receive your paycheck, so saving is automatic; plus you do not pay federal income tax on the portion of your salary that you contribute to your account until you make a withdrawal. This tax savings means it costs you less to contribute to the Plan than if you had contributed to a regular after-tax savings account. If you want to make participant contributions to the Plan from your salary, you will need to make a salary reduction election which states the flat dollar or percentage amount by which you will have your paycheck reduced before taxes are taken.

Think of it this way: Participating in the Plan is like receiving a bonus each year. Sunset Park Health Council's contribution to your account is in addition to your salary; an addition which builds security for your future.

Before You Begin

This booklet is a summary of the Plan's most important features. In the course of reading this summary, you may come across some words and phrases that have specific meaning within the context of the Plan. To help you understand these terms, they are defined in the text. Additionally, please read the "Other Information You Should Know" section of this booklet for important information and facts about your rights as a participant of the Plan.

The NYU Langone Health Human Resources Department oversees the day-to-day operations of the Plan on behalf of Sunset Park Health Council. You can reach the NYU Langone Health Human Resources Department at **212-404-3787** or **NYULMCBenefits@nyulangone.org**.

TIAA is the Plan's sole recordkeeper. TIAA is an important source of information about the Plan. To contact TIAA with questions or to access your account, you have several choices:

- You can call the dedicated customer service center at **855-200-7240**.
- If you are an active employee of Sunset Park Health Council, you can log on to **www.atnyulmc.org** with your Kerberos ID and password. Click on "Human Resources" from the top navigation, and then click on "Retirement Savings". On the "Retirement Savings" page, click on the "Manage my Account" button.
- Go online to **TIAA.org/retiresphc**. You will need a user ID and a password.

HOW THE PLAN WORKS

Sunset Park Health Council makes an employer contribution to your account after each paycheck while you are an eligible participant. For this reason, this type of plan is called a "defined contribution" plan. The Plan is authorized under Section 403(b) of the Internal Revenue Code. You may elect to make participant contributions to the Plan from your paycheck through salary reductions. This means that your participant contributions are taken out of your pay before taxes are applied, thus reducing your taxable pay. One of the advantages of this Plan is that you can reduce your current federal income tax by participating, as explained later in this booklet. Your account balance depends on the amount of money that is contributed to your account before you retire and how this money grows through investment by the time you reach retirement. Your contributions and any investment earnings on them are tax deferred until they are withdrawn.

ELIGIBILITY AND PARTICIPATION

Who Can Participate?

You are eligible for employer contributions under the Plan if you:

- Are employed by Sunset Park Health Council in an eligible job position, **excluding** the following positions:
  - Interns, Students, Medical or Dental Residents, Fellows, a union position unless the collective bargaining agreement provides for eligibility in the Plan with respect to employer contributions, Per Diem employees, a leased employee, and Temporary (e.g., seasonal or project hire) employees.
- Are a "Regular Eligible Employee", which means you are normally scheduled to work at least 50% Full-Time Equivalent (FTE) for your job position, and
- Have met the applicable waiting period.

Employees who are nonresident aliens with no U.S. source of income are not eligible for employer contributions under this Plan.

If you otherwise would be eligible to receive an employer contribution for a plan year if you are scheduled to work less than 50% FTE, you will be eligible to receive an employer contribution for that year if you are employed by Sunset Park Health Council on the last day of the year and are credited with at least 1,000 hours of service in that year.

There is no waiting period to make participant contributions to the Plan. You are eligible to make participant contributions to the Plan if you are a Sunset Park Health Council employee, except that you are not eligible if you are a nonresident alien with no U.S. source of income or a leased employee.

Satisfying the Applicable Waiting Period

If you are a Regular Eligible Employee, you will meet the waiting period effective with the first pay period coinciding with or next following your completion of 90 days of employment with Sunset Park Health Council.

If you are scheduled to work less than 50% FTE for your job classification, you will meet the waiting period effective with the first pay period coinciding with or next following completion of a year of service in which you are credited with at least 1,000 hours. The twelve-month year period used to measure service for this purpose is your first twelve months of employment and each calendar year beginning after your date of hire. In general, you are credited with hours of service for hours you work and for certain other hours for which you are entitled to be paid (such as paid vacation and holidays).

For purposes of the waiting period, your NYU Langone Hospitals, NYU Grossman School of Medicine (formerly NYU School of Medicine) and NYU Langone Health System, NYU Langone MSO, Inc., NYU Imaging, Inc.** on or after August 1, 2018 (see note on Meridian Service below), and NYU Langone Hospital—Long Island* service is recognized under the Plan if you were employed by one of these employers with no intervening employment prior to becoming a Sunset Park Health Council employee. Please contact the NYU Langone Health Human Resources Department if you were previously employed by any other NYU Langone employer.

***NYU Langone Hospital—Long Island Service:** If you were hired at Sunset Park Health Council on or after January 1, 2018, any continuous service at NYU Langone Hospital—Long Island (and its predecessor NYU Winthrop Hospital or Winthrop University Hospital) for periods prior to the date on which you were hired by Sunset Park Health Council will be treated as service with Sunset Park Health Council for purposes of eligibility and vesting.

****Meridian Service:** If you were employed at Meridian Imaging, Inc. prior to becoming an employee of NYU Imaging on or about August 1, 2018, and then transferred to Sunset Park Health Council with no intervening employment, up to one year of service with Meridian Imaging, Inc. and all service with NYU Imaging with be treated as service with Sunset park Health Council for purposes of eligibility and vesting.

When Do You Participate?

You are eligible for employer contributions with the first pay period coinciding with or next following your satisfaction of the applicable waiting period or, if later, the date on which you become eligible for employer contributions.

There is no waiting period for participant contributions. You will be auto-enrolled in the Plan with a 4% payroll deduction if you take no action to make an election or opt out of this feature. Review the "Participant Contributions" section for more details.

Note: If your employment transfers from NYU Grossman School of Medicine, NYU Langone Hospitals, NYU Langone Health System, or NYU Langone MSO, Inc. you must make a **new** salary reduction election under this Plan. If you take no action you will be auto-enrolled with a payroll deduction of 4%.

Designation of Beneficiary

When you first join the Plan, you must designate a beneficiary for your account. If you die before you begin to receive service retirement income, your beneficiary(ies) will receive the value of the accumulation as a death benefit. You may change your beneficiary at any time, but certain rules on beneficiary designation apply:

- If you are married, your spouse must be your beneficiary for at least 50% of your plan benefits, unless you and your spouse sign a Waiver of Spouse's Right to a Preretirement Survivor Death Benefit; and
- The waiver can be signed only if you are age 35 or older, and must be signed in the presence of a notary public.

If you do not designate a beneficiary, your default beneficiary will be your surviving spouse or, if none, your estate (except as otherwise specified under the terms of a particular annuity contract or custodial account agreement).

CONTRIBUTIONS TO THE PLAN

Employer Contributions

Once you are eligible, Sunset Park Health Council contributes 6% of your eligible salary each pay period to the Plan if you are a Regular Eligible Employee. Contributions are made for each paycheck and continue for as long as you continue to be a Regular Eligible Employee. You are not required to make participant contributions in order to receive employer contributions.

If you are scheduled to work less than 50% FTE and you have completed a year of service, you will be eligible to receive an employer contribution for that plan year if you are employed on the last day of the year and are credited with at least 1,000 hours of service in that year. Sunset Park Health Council will contribute 6% of your eligible salary for the year after the end of the plan year.

A separate discretionary non-elective employer contribution may be available at the end of the Plan Year. The discretionary non-elective employer contribution is equal to a percentage of your eligible salary (as determined by Sunset Park Health Council). In order to receive the discretionary non-elective employer contribution (if available), you need to be employed on the last day of the Plan Year (12/31), and if you are scheduled to work less than 50% FTE you must also have 1,000 hours of service in the Plan Year.

Participant Contributions

If you are eligible, you may make participant contributions to the Plan as early as the first available paycheck once you make a salary reduction election. If you are hired or transferred to Sunset Park Health Council on or after January 1, 2020, you will be auto-enrolled in the Plan with a 4% payroll deduction. You have 30 days to opt out of the auto-enrollment feature or make a salary deferral election. If you fail to opt out during this period and have had payroll deductions, you will have 60 days from the date you were auto-enrolled to request a refund of those deductions. You must contact TIAA directly to request a refund of deductions. Auto-enrollment does not apply to an employee who is covered by a collective bargaining agreement between a union and Sunset Park Health Council. You can continue to make participant contributions as long as you remain employed at Sunset Park Health Council, even if you are no longer in a position that is eligible for the employer contribution. You can elect to make your participant contributions as a whole percentage of your eligible salary, a flat dollar amount, or the IRS maximum contribution. If you elect the IRS maximum contribution option, your participant contributions will automatically increase when the IRS limits increase. Note: If you have elected the Maximum and you are at least age 50 by the end of the plan year, you will be automatically enrolled in the full age 50 catch-up contribution. **If you contributed any 403(b) or 401(k) money to another employer during the Plan Year, be sure to enter this in on the applicable page of the TIAA site. Failure to do so may result in over-deferring for the year, which can result in tax penalties.** You can start, stop or change the amount you contribute from your paycheck at any time and as frequently as you need. The Plan has a voluntary auto-increase feature which helps you build your savings faster. This feature enables you to automatically increase your contributions by a percentage. You select the percentage, frequency and start date of your automatic increases. In addition, you set the cap and indicate when you would like to stop the automatic increases. To enroll or manage your account, log on to **www.atnyulmc.org** with your Kerberos ID and password. Click on "Human Resources" from the top navigation, and then click on "Retirement Savings". On the "Retirement Savings" page, choose "Manage my Account" if you already enrolled in the Plan and want to restart, stop or change the amount you contribute from your paycheck. If you are enrolling for the first time, click on the "Enroll Now" option from the "Retirement Savings" page. Note that there is a payroll cutoff date; if you make your elections by the applicable date, they should be applied in the next pay cycle.

Note: Participant contributions are **not** deducted from off-cycle paychecks (except for replacement checks for regular cycle paychecks).

Rollover Contributions

You are permitted to make "rollover contributions" to the Plan, and your rollover contributions will be subject to the same rules as your participant contributions. In order to make such a contribution, you must demonstrate to the Plan Administrator that the contribution is eligible as a "rollover contribution" under the provisions of the Internal Revenue Code and satisfies the Plan's requirements for rollover contributions. Contact TIAA for more information about how to make a rollover contribution to the Plan.

Eligible Salary

"Eligible salary" means:

- For purposes of employer contributions, the base salary paid to an employee by Sunset Park Health Council plus any base salary that is subject to a pretax election under Internal Revenue Code section 125, 132(f)(4), 403(b), or 457(b). Overtime, bonuses, shift

differential, overloads, deferred compensation, severance payments, cash payments of accrued vacation or paid time off upon termination of employment, faculty practice or other private practice income, and any additional compensation are excluded for purposes of employer contributions.

- For purposes of participant contributions, the cash compensation paid to an employee by Sunset Park Health Council, plus compensation that is subject to a pretax election under Internal Revenue Code section 125, 132(f)(4), 403(b), or 457(b), but excluding any imputed income, allowances, subsidies, and other payments not earned by the employee for the performance of their duties.

Salary in excess of the IRS annual limit cannot be considered under the Plan for employer contributions. (This limit is $305,000 for 2022 and it may be increased from time to time in accordance with the Internal Revenue Code.) Amounts paid after severance from employment are not included in eligible salary unless they are payments of regular pay or paid time-off cashouts made by the later of 2½ months after severance from employment or the last day of the calendar year in which the severance from employment occurs, as long as the amounts would have been included if paid prior to severance from employment.

Vesting

When you are fully vested, that means you have a nonforfeitable right to the money in your accounts (including any investment earnings on contributions). You are always 100% vested in the following:

- Your participant contributions under the Plan.
- The 6% non-elective employer contribution.

With respect to the discretionary non-elective employer contribution, the Plan's vesting provisions are as follows:

Years of Service	Vesting Percentage
Less than 1	0%
1 but less than 2	20%
2 but less than 3	40%
3 but less than 4	60%
4 but less than 5	80%
5 or more	100%

If you are a Regular Eligible Employee, you will earn a year of vesting service for each calendar year in which you are credited with at least 975 hours of service. All other employees earn a year of vesting service for each calendar year in which they are credited with at least 1,000 hours of service. Generally, you are credited with an hour of service for each hour you are paid or entitled to payment for the performance of duties. Also included are certain nonworking hours such as vacation, holiday and jury duty hours, up to 501 hours in any continuous period. Service with certain NYU Langone employers may count for purposes of vesting under the Plan.

If your employment with the Sunset Park Health Council terminates before you are 100% vested, the unvested portion of your employer contribution account will be forfeited upon the earlier of the distribution of your vested Plan benefits or the expiration of five consecutive calendar years in which you are not credited with at least 501 hours of service. If you return to employment with Sunset Park Health Council before the expiration of that five-year period, and have already taken a distribution of the vested portion of your employer contributions, your forfeited account balance will be restored (without interest). If your employment terminates after you are 100% vested in the Plan and you return to employment at any time you will not need to meet another vesting period.

Limits on Contributions

You should be aware that the federal government places a limit on the annual amounts that you can contribute to tax-favored retirement plans for the calendar year. For 2022 the limit is $20,500 if you are under age 50, and $27,000 if you are 50 or older. In addition, federal law limits the total "annual additions" that can be contributed to certain tax-favored retirement plans on your behalf. For 2022 this limit is $61,000. If you participate in another retirement plan during a calendar year, please check with a tax advisor and notify TIAA. In addition, you may also be eligible to contribute to the 457(b) Plan. Please contact the NYU Langone Health Human Resources Department for more information.

CHOOSING INVESTMENTS

TIAA has been selected by Sunset Park Health Council to offer investment options under the Plan. When you join the Plan, you decide how the money in your account is invested. The Plan offers a range of investment funds from which to choose, so that you can choose the investments that are right for you. Currently, the Plan offers many Vanguard mutual funds and several TIAA and CREF options. More details about selecting your investment options can be found in the "Manage your Account Online" guide, available at **www.atnyulmc.org**. Click on "Human Resources" from the top navigation, and click on "Retirement Savings", then click on "How to Manage your Account" under "Related Information."

Before making any investment decision, you should read the TIAA booklet and the prospectuses for each fund in which you may wish to invest. Some of the funds available involve moderate to substantial investment risk and do not guarantee your principal or investment return.

You can order prospectuses directly from TIAA by calling the dedicated customer service center at **855-200-7240**. You may also download or view prospectuses by visiting the TIAA website at: **TIAA.org/retiresphc**.

If you do not provide affirmative investment directions, your account will be invested in the Plan's default investment fund. Prior to February 11, 2022, the default fund was the Vanguard Institutional Target Retirement Fund appropriate to your age.* As of February 11, 2022, the default fund is the Vanguard Target Retirement Funds (Investor). Target retirement funds automatically adjust your investment allocation, determined by your age and date of retirement.

**Although target retirement funds can simplify investment selection, all mutual fund investing is subject to risk. Diversification does not ensure a profit or protect against a loss. Sunset Park Health Council is not in a position to offer you investment advice, and no person at Sunset Park Health Council or in the NYU Langone Health Human Resources Department is authorized to give you such advice.*

Keep in mind that any investment carries a degree of risk. As a result of your investment election, your account may increase or decrease in value, and the annual rate of return on your account will vary depending on the funds in which you invest. How the funds have performed in the past does not guarantee that those results will continue. It is up to you to monitor the funds and to make investment elections that meet your own financial goals.

Your participant contributions and Sunset Park Health Council's employer contributions will continue to be invested in your initial choice of funds (or in the applicable Vanguard Target Retirement Fund if you do not provide an affirmative investment direction) until you make a change. Two kinds of investment changes can be made: You can put future contributions in a new investment choice (reallocate) and/or you can move existing account balances from one fund to another (transfer).

Reallocating Your Future Contributions

You can change the investment of future contributions at any time by logging on to the TIAA website or by calling their toll-free number.

Transferring Existing Account Balances

You can transfer existing Sunset Park Health Council account balances from one fund to another. These transfers can be made at any time by calling TIAA's toll-free number or logging on to the TIAA website.

Note: Some funds may have restrictions on transfers; check with TIAA for details.

Tracking Your Investments

TIAA issues quarterly statements that are mailed directly to your home or provided to you online at an email address you specify, so you know the balances and current asset allocations of your accounts. In addition, there are several ways that you can get up-to-date information on the value of your investments:

- To track your investments while you are still employed at Sunset Park Health Council go to **www.atnyulmc.org**, click on "Human Resources" from the top navigation, and click on "Retirement Savings". On the "Retirement Savings" page, click on "Manage my Account" if you already enrolled in the Plan.
- Once you leave Sunset Park Health Council, you can track your investments by going to **TIAA.org/retiresphc**. You'll need a user ID and password.
- You can call the dedicated customer service center at **855-200-7240**.

Responsibility for Investment Decisions

The Plan is intended to constitute a plan described in section 404(c) of the Employee Retirement Income Security act of 1974 ("ERISA") and Title 29 of the Code

of Federal Regulations Section 2550.404c-1. The Plan offers you and your beneficiaries the opportunity to exercise control over the assets contributed and accumulated on your behalf under the Plan by allowing you to choose, from a broad range of investment alternatives, the manner in which these assets will be invested and by providing you with information necessary to make informed decisions with respect to the investment options under the Plan and the incidents of ownership that arise from those investments. The Plan Administrator is the named fiduciary which is obligated (with certain limited exceptions) to comply with these instructions. As a result of the foregoing, fiduciaries of the Plan may be relieved of liability for any losses which are the direct and necessary result of your investment instructions. The Plan Administrator reserves the right to change the investment options offered under the Plan from time to time (including the Plan's default investment fund). You will periodically receive required participant fee disclosure from TIAA, and you may obtain the additional information concerning the investment options available under the Plan by contacting TIAA at any time, including information about fund performance, fees and expenses (e.g., investment management fees, administrative fees, transaction costs) which reduce the rate of return to participants and beneficiaries, and copies of any prospectuses, financial statements and reports.

You are strongly urged to carefully read all descriptions and disclosure materials relative to investment options under the Plan before making investment decisions. There may be commissions, sales charges, redemption or exchange fees, or other transaction fees or expenses which directly affect your account under the Plan. Additionally, the funds underlying the investment options you select may themselves pay certain fees to their investment advisors or other service providers. Any such fees or expenses, whether deducted directly from your account or paid indirectly by the investment vendor or the underlying funds, effectively reduce the return on your account. For more specific information, please consult the investment information (including prospectuses) provided to you by TIAA, or contact TIAA directly.

Forms and Tools Online

TIAA has a customized website designed specifically for Sunset Park Health Council employees. This site offers tools to enroll and make Plan elections, monitor your current account balances and the way you have your funds invested, and learn more about the Plan and saving for retirement (including detailed Plan and fund information, retirement planning calculators, and Plan-related forms). You can also access additional information about planning and investing for retirement by choosing the "Advice & Planning" tab.

WITHDRAWALS/DISTRIBUTIONS OF YOUR PLAN ACCOUNTS

In-service Withdrawals Before Retirement or Severance from Employment

Generally, withdrawals cannot be made while you are employed by Sunset Park Health Council, except that you may make a withdrawal from your rollover contributions at any time. Subject to rules described below in more detail and the applicable TIAA rules, in-service withdrawals may be made when you:

- Reach age 59½,
- Are permanently disabled as evidenced by a Social Security award letter, or
- Suffer a serious financial hardship.* (Serious financial hardship will be determined by the Plan Administrator of the Plan in accordance with current IRS regulations.

**Hardship withdrawals made prior to age 59½ are subject to the 10% penalty tax for certain early withdrawals.*

In addition, you may be eligible to take a loan from the Plan. Please contact TIAA for more information or to initiate a withdrawal or a loan. Spousal consent is required if you are married.

Age 59½ Withdrawals

The following in-service withdrawal rules apply if you have attained age 59½:

- You may withdraw any participant contributions plus related investment earnings.
- If you have base hours of no more than 20% of a full-time schedule, you may make a withdrawal of all or a portion of your employer contributions, plus related investment earnings. (If you have base hours of more than 20% of a full-time schedule, you cannot take a withdrawal from your employer contributions.)

Withdrawals on Account of Disability

If you become disabled (meaning that you are unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or be of long-continued and indefinite duration), as evidenced by a Social Security award letter, you may withdraw all or a portion of your Plan accounts attributable to participant contributions plus related investment earnings.

Hardship Withdrawals

If you experience a qualified financial hardship as defined by the IRS, as a last resort, withdrawals can be made available to you only from your participant contributions if you can substantiate an **immediate and heavy financial need**. Documentation for the hardship withdrawal will be required as well.

The following outlines what the Internal Revenue Service defines as a qualified financial hardship:

- Payment of uninsured medical expenses for you, your spouse or dependents as described by IRS publication 502 in effect for the year of withdrawal;
- Payment of costs directly related to the purchase of your principal residence (excluding mortgage payments);
- Payment of tuition, related educational fees, and room and board expenses for up to the next 12 months of post-secondary education for you, your spouse, children or dependents;
- Payment of amounts needed to prevent your eviction from your principal residence or to prevent foreclosure on your principal residence;
- Payments for burial or funeral expenses for your deceased parent, spouse, children or dependents; or
- Expenses for the repair of damage to your principal residence that would qualify for the casualty deduction under Code section 165 (determined without regard to whether the loss exceeds 10% of adjusted gross income).
- Expenses and losses (including loss of income) incurred by you on account of a disaster declared by the Federal Emergency Management Agency ("FEMA") under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, provided that your principal residence or principal place of employment at the time of the disaster was located in an area designated by FEMA for individual assistance with respect to the disaster.

If you received a hardship withdrawal prior to January 1, 2019, then any Salary Reduction Election then in effect was suspended until the last day of the 6-month period beginning on the date the hardship withdrawal was approved. Any suspension in effect on December 31, 2018 was treated as expired as of January 1, 2019. Effective January 1, 2019, salary reduction elections are no longer suspended if you receive a hardship withdrawal.

Loans

In recognition that participants sometimes encounter shorter term needs for assets, the loan feature of the Plan permits you to borrow only your participant contributions, your rollover contributions and any investment earnings on those contributions. Loans are not available from employer contributions. An eligible borrower is a participant who is an employee or a participant (or a deceased Participant's beneficiary) who is a "party of interest" within the meaning of ERISA section 3(14). An Eligible Borrower is permitted to have no more than two outstanding loans at any time. If an eligible borrower has defaulted on a prior loan, they will not be permitted to initiate a new loan.

When you borrow from the Plan, the amount of the loan is not taxable, unless you default on the loan by not making one of the quarterly repayments on a timely basis to TIAA. The minimum loan amount is $1,000. The maximum loan amount is the lesser of $50,000 (reduced by the highest aggregate outstanding loan balance you may already have under the Plan or 50% of your total account balance or the maximum loan amount imposed by TIAA. (Special restrictions may apply if you have an outstanding loan or if you have already defaulted on a loan under the Plan.) Please contact TIAA for more information.

Keep in mind that spousal consent is required for a loan if you are married. All consents by a spouse must be in writing, notarized and contain an acknowledgement by your spouse to the effect of the consent. All such consents are irrevocable. When initiating the loan, the spousal consent form will be included in the loan documents and required for the loan to be processed.

Note: Loans are not available from the plan after termination of employment.

When You Leave Sunset Park Health Council

When your employment with Sunset Park Health Council ends, you have several options:

- You may keep your account invested through the Plan. You will continue to enjoy the investment options currently available, and you may transfer from one investment option to another in accordance with the rules of the plan.
- You may cash out of your investments (unless you are invested in a TIAA annuity, which can only be cashed out over a ten-year period). Keep in mind, however, that income taxes will apply to the amounts you cash out. Also, if you cash out your investments before age 59½, a 10% federal tax penalty may apply.
- You may roll over your account balance to an individual retirement account (IRA) or another eligible retirement plan. To avoid tax consequences, the rollover should be made directly from the Plan to the IRA account or other eligible retirement plan. Tax laws change frequently and you should obtain current information at the time of your termination of employment.
- You will need your spouse's notarized consent for any withdrawal that is not in the form of a 50% Joint and Survivor Annuity.

Note: The TIAA Retirement Annuity Contract does not offer a single-sum payout option at this time.

Forms of Payment

Once you retire from or leave Sunset Park Health Council you can receive income from the Plan at any time. You can elect immediate payment in a single sum, make partial withdrawals, or choose an annuity. An annuity provides a monthly income which you cannot outlive; the plan offers many types of annuities, including those that will provide an income to a surviving spouse. You may also delay receiving any form of benefit until your "required beginning date." Your required beginning date is April 1 of the year following the later of the year in which your employment with the NYU controlled group terminates and the year in which you attain age 72 (or, if you turned age 70½ before January 1, 2020, the year in which you attained age 70½). The payment choices give you the flexibility to tailor the payment to suit your needs. If you are married, you must receive your benefits in the form of a 50% Joint and Survivor Annuity unless you and your spouse elect otherwise. This means you will receive benefits for your lifetime and, if you are survived by your spouse, your spouse will receive a monthly benefit of one-half of the amount you were receiving. To receive a different form of payment, you and your spouse must sign a waiver in the presence of a notary public. Please contact TIAA for more information about the Plan's payment options or to request a distribution.

Note: Federal law requires that you commence payments of your Plan benefits no later than your required beginning date and that you receive a required minimum distribution for each year thereafter for as long as you have an account under the Plan. (If you delay distributions until your required beginning date, you will have two required minimum distributions in the year of your required beginning date.) If you fail to take your required minimum distributions, you may owe significant tax penalties. Please contact for TIAA for more information about how to satisfy the required minimum distribution rules.

Benefits Upon Death

If you die while your benefits are still invested in the Plan, your benefits will belong to your designated beneficiary. You may change your beneficiary(ies) at any time (see page 2). If you are married, your spouse must be your beneficiary for at least 50% of your Plan benefits, unless you and your spouse sign a waiver. A waiver can only be signed if you are age 35 or older, and must be signed in the presence of a notary public. Please see Spousal Consent below for more information. If you die after you have elected a retirement annuity, death benefits (if any) will depend on the terms of the annuity you have chosen.

Spousal Consent

All consents by a spouse must be in writing, notarized, and contain an acknowledgement by your spouse to the effect of the consent. Consent of your spouse to alternative benefits forms or withdrawals must be made within 180 days prior to the first day of the period for which the payment or withdrawal applies. All such consents shall be irrevocable. The consent must specifically designate the beneficiary or otherwise expressly permit designation of the beneficiary by you without any further consent by your spouse. If a designated beneficiary dies, unless the express right to designate a new one has been consented to, a new consent is necessary. A consent to a form of benefit other than a Joint & Survivor Annuity must either name another specific form of benefit or expressly permit designation by you without further consent.

A consent is only valid so long as your spouse at the time of your death benefit commencement or withdrawal, as the case may be, is the same person as the one who signed the consent.

Note: Spousal consent is not required if you are legally separated and have a court order to that effect.

Rights to Your Account

Your vested rights under this Plan cannot be assigned or used as collateral. They are not subject to garnishment or attachment (except by the Internal Revenue Service under a properly executed levy). However, the Plan is required to obey a Qualified Domestic Relations Order from a court requiring payment for the purpose of child support, alimony or other marital payments.

A Qualified Domestic Relations Order is a court order providing for child support, alimony or marital property rights to a spouse, former spouse, child or other dependent, according to a state domestic relations law. It must satisfy certain requirements under federal law. You may obtain a copy of the Plan's procedures for reviewing such orders at no charge by contacting TIAA.

TAXATION OF YOUR ACCOUNT

By participating in the Plan, you can reduce your taxes and save money at the same time:

- The amount of salary you put into the Plan is not subject to current federal income tax. You agree to reduce your eligible salary by an amount and, instead of paying you this amount in wages, Sunset Park Health Council contributes it to your account. Because the money never actually goes into your paycheck, it is not taxed as income. This special arrangement is authorized under Section 403(b) of the Internal Revenue Code, so sometimes this kind of retirement plan is called a 403(b) plan. You save federal, New York State, and New York City taxes on the amount of salary that goes into the plan (see the note below regarding tax implications in other localities). The money that you would have paid in taxes is instead invested and earning interest or investment return. Taxes are not applied as long as the money stays in the Plan but, once it is withdrawn, ordinary taxes apply.
- Sunset Park Health Council's contributions are tax deferred so long as they remain in the Plan.
- Investment earnings are tax deferred. That means any investment returns will grow faster because they won't be taxed each year.
- Benefits are taxed as ordinary income when received. If your employment ends, you can postpone taxation by keeping your accounts invested in the Plan until the aforementioned required beginning date as described on the previous page. If you choose to receive payments before age 59½, your payments may be subject to a 10% federal tax penalty in addition to regular income tax. However, the 10% tax penalty will not apply if payment is made before age 59½ because of your death or disability, or upon a retirement at age 55 or older. Payments to a nonparticipant under a divorce court order are also not subject to the 10% penalty and are taxable to the recipient rather than to the participant.

This section describes some of the most important rules under which your accounts are taxed. Because tax laws and regulations are complicated and change frequently, you should obtain further information specific to your situation before making a withdrawal from your accounts.

A Note on State Practices

State taxes are not discussed in this booklet in detail because tax laws can differ from state to state. Most states agree, however, on the question of taxing your contributions under Section 403(b). At the time of publication, salary-reduction contributions (up to the federal limit) escape current taxes in all but two states: New Jersey and Pennsylvania.

OTHER INFORMATION YOU SHOULD KNOW

Commencing Benefits

To receive benefits, you must file benefit distribution forms, which are available from TIAA.

Claims and Appeals

The Plan has written procedures for reviewing claims and appeals, and a copy of these procedures is attached to the end of this booklet. If you believe you have been denied a benefit under the Plan, you or your beneficiary (or authorized representative) may file a claim with the Plan's "Claims Manager," as described in the procedures. If your claim is denied, you or your authorized representative will receive written notification within 90 days after the date the Plan Administrator receives the claim (unless the period is extended under the Plan's procedures). Within 60 days after receiving the denial, you or your duly authorized representative may then submit a written request for reconsideration of the claim to the Claims Manager. Any such request should be accompanied by documents or records in support of the appeal. You or your duly authorized representative may review pertinent documents and submit issues and

comments in writing. You or your duly authorized representative will receive a written response to the appeal no later than 60 days after it is received (unless the period is extended under the Plan's procedures).

If the appeal is denied, the notice will include the specific reasons for the denial with reference to the specific Plan provisions on which the determination is based, a statement that you or your beneficiary is entitled to receive, upon request and at no charge, reasonable access to and copies of all documents, records and other information relevant to the claim, and a statement of your right to bring a civil action under Section 502(a) of ERISA. If the appeal is denied, it is final and binding on all parties.

Special rules may apply if the claim involves a disability benefit. Please see the attached procedures for complete details about the claims and appeals process.

When Participation Ends

You will cease active participation in the Plan when you leave Sunset Park Health Council or transfer into an ineligible job category.

Insured Benefits

All contributions made under the Plan are paid directly into your accounts. The benefit you receive is based on the amount in your retirement plan accounts. Your account is not insured by any governmental agency, such as the Pension Benefit Guaranty Corporation (which insures only defined benefit plans, not defined contribution plans).

Effect on Other Benefits

Social Security and other benefits will continue to be based on your full, unreduced salary and will not be affected by your contributions under this Plan.

How to Get Answers to Your Questions

The Plan has a dedicated call center to assist you. You can reach the call center by phone at **855-200-7240**. Or, if you are still employed by Sunset Park Health Council, log on to **www.atnyulmc.org**. Click on "Human Resources", and then select "Retirement Savings", click on "Manage my Account" if you already enrolled in the Plan and want to restart, stop or change the amount you contribute from your paycheck. If you are enrolling for the first time, click on the "Enroll Now" option from the "Retirement Savings" page. Once you leave Sunset Park Health Council you can access your account at **TIAA.org**, using the user ID and password you created. You can also contact the NYU Langone Health Human Resources Department at **212-404-3787**, or by email at **NYULMCBenefits@nyulangone.org**.

Compliance with Federal Laws

The Plan is governed by current tax and other federal law as well as the rulings of the Internal Revenue Service and the Department of Labor. The Plan will always be construed to comply with these laws and rulings. If there are any changes in applicable law or governmental rulings, the Plan will be amended as required to stay in compliance. You will be kept informed of any changes as may be required by law.

Future of the Plan

Sunset Park Health Council plans to continue to offer the Plan to all eligible employees. Sunset Park Health Council however, reserves the right to change, terminate, suspend, withdraw, reduce, amend, or modify the Plan at any time.

Your Rights Under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974. Plan participants are entitled to:

- Examine, without charge, at the NYU Langone Health Human Resources Department and other specified locations (such as worksites and union halls), all documents governing the Plan, including collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Plan Administrator with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of the documents governing the operation of the Plan, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) and updated summary plan description, upon written request to the NYU Langone Health Human Resources Department. The Human Resources Department may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Obtain upon request a statement telling you (1) the amounts credited to your account under the Plan; and (2) the total amount you would receive if you stopped

working under the Plan now. This statement must be requested in writing and is not required to be given more than once a year. The Plan must provide this statement free of charge.

In addition to creating rights for plan participants, ERISA imposes obligations upon the people who are responsible for the operation of the Plan. People who operate the Plan are called fiduciaries. The fiduciaries of the Plan have a duty to operate the plan prudently and in the interests of the Plan participants and beneficiaries. No one, including Sunset Park Health Council, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

- If your claim for benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the rights listed above. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In this case, the court may require the plan administrator to pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator's control.
- If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If the plan fiduciary misuses the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you win, the court may order the person you have sued to pay those costs and fees. If you lose, the court may order you to pay those costs and fees. If you have questions about this Plan, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or send correspondence to:

Division of Technical Assistance & Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

You can also visit the U.S. Department of Labor's website at **www.dol.gov**.

PLAN FACTS

Official Plan Name
Sunset Park Health Council 403(b) Plan

Plan Number
001

Type of Plan
Internal Revenue Code section 403(b) defined contribution plan

Plan Sponsor
Sunset Park Health Council
c/o NYU Langone Health
Human Resources Department
One Park Avenue 4th Floor
New York, NY 10016
212-404-3787
Email: **NYULMCBenefits@nyulangone.org**

Employer Identification Number
20-2508411

Plan Year
January 1 – December 31

Plan Administrator
Sunset Park Health Council
c/o NYU Langone Health
Human Resources Department
One Park Avenue 4th Floor
New York, NY 10016
212-404-3787
Email: **NYULMCBenefits@nyulangone.org**

Agent for Service of Legal Process
If, for any reason, you wish to seek legal action, you may serve legal process on the Plan sponsor at the following address:

Office of Legal Counsel
Sunset Park Health Council
530 First Avenue
Schwartz Building, HCC-15th Floor
New York, NY 10016

Plan Funding

Contributions to this Plan are made by the Plan Sponsor or in accordance with salary reduction elections made by eligible employees. Benefits are provided under annuity contracts with designated insurance companies and custodial accounts invested in designated mutual funds.

Issue Date: January 2022

SUNSET PARK HEALTH COUNCIL CLAIMS AND APPEALS PROCEDURES

NYU Grossman School of Medicine Retirement Plan for Members of the Faculty, Professional Research Staff and Administration

NYU Grossman School of Medicine Management and Staff 403(b) Plan

NYU Langone Hospitals 403(b) Plan

NYU Langone Health System 403(b) Plan

NYU Langone Florida 403(b) Plan

NYU Langone Hospitals Retirement Plan

NYU Langone Hospital-Brooklyn UFT Retirement Plan

These Procedures for filing and reviewing Claims (as defined below) have been established under the retirement plans listed above (each referred to as the "Plan" or, collectively, the "Plans" or the "Retirement Plans") and are intended to comply with Section 503 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and the related Department of Labor Regulations. They are effective for Claims made under the Plans on or after July 1, 2012. The "Plan Administrator" of each Plan has delegated the responsibility for reviewing and resolving Claims to certain individuals as described more fully below. The term "Plan Administrator" shall refer to New York University, NYU Langone Hospitals, NYU Langone Health System, or NYU Langone MSO, Inc., as applicable, or any committee appointed by New York University or NYU Langone Hospitals, NYU Langone Health System, or NYU Langone MSO, Inc., to serve as Plan Administrator. Paragraph 11 and Appendix A provide additional procedural safeguards that apply to certain "Disability Claims" (as defined below).

1. In General

Any employee or former employee of New York University, NYU Langone Hospitals, NYU Langone Health System, NYU Langone MSO, Inc., or their affiliates, or any person claiming to be a beneficiary of such person or an "alternate payee" named in a qualified domestic relations order with respect to such person, may:

- Request a benefit payment from a Plan;
- Request a resolution of a disputed amount of benefit payment from a Plan; or
- Request a resolution of a dispute as to whether the person is entitled to the particular form of benefit payment under a Plan.

A request described above and filed in accordance with these Procedures is a "Claim," and the person on whose behalf the Claim is filed is a "Claimant." A Claim must relate to a benefit which the Claimant asserts he or she is already entitled to receive or will become entitled to receive within one year following the date the Claim is filed.

2. Effect on Benefit Requests in Due Course

The Plans have established procedures for benefit applications, selection of benefit forms, designation of beneficiaries, determination of qualified domestic relations orders, and similar routine requests and inquiries relating to the operation of the Plans. Many of these are set forth in the Summary Plan Descriptions for the Plans or other materials provided to employees, or are available by contacting the Director of Benefits identified in Paragraph 3 below or a member of the Human Resources Department at the site of the employee's employment. Such routine requests and applications are not "Claims" to be resolved under these Procedures and must be utilized fully before filing a Claim. However, an employee, former employee, or individual claiming to be a beneficiary or alternate payee, who disputes a determination resulting from such routine processing, may then file a Claim as described above.

3. Filing of Claims

Each Claim must be in writing and delivered by hand or first-class mail (including registered or certified mail), as follows:

Director of Benefits
NYU Langone Health
One Park Avenue 4th Floor
New York, NY 10016

The Director of Benefits shall be the "Claims Manager" for all Claims. A Claim must clearly state the specific outcome being sought by the Claimant. The Claim must also include sufficient information relating to the identity of the Claimant and such other information reasonably necessary to allow the Claim to be evaluated.

4. Processing of Claims

A Claim normally shall be processed and determined by the Claims Manager within a reasonable time (but no longer than 90 days) following actual receipt of the Claim. However, if the Claims Manager determines that additional time is needed to process the Claim and so notifies the Claimant in writing within the initial 90-day period, the Claims Manager may extend the determination period for up to an additional 90 days. In addition, where the Claims Manager determines that the extension of time is required due to the failure of the Claimant to submit information necessary in order to determine the Claim, the period of time in which the Claim is required to be considered pursuant to this Paragraph 4 shall be suspended from the date on which notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information. Any notice to a Claimant extending the period for considering a Claim shall indicate the circumstances requiring the extension and the date by which the Claims Manager expects to render a determination with respect to the Claim. The Claims Manager shall not process or adjudicate any Claims relating specifically to his or her own benefits under a Plan.

5. Determination of Claim

The Claims Manager shall inform the Claimant in writing of the decision regarding the Claim by first class mail within the time period described in Paragraph 4 above. The decision shall be based upon governing Plan documents. If there is an adverse determination with respect to all or part of the Claim, the written notice shall include:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provisions on which the denial is based;
- A description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary; and
- Reference to and a copy of these Procedures, so as to provide the Claimant with a description of the Plan's review procedures and the time limits applicable to such procedures, a description of the Claimant's rights regarding documentation as described in Paragraph 9, and a statement of the Claimant's rights under Section 502(a) of ERISA to bring a civil action with respect to an adverse determination upon review of an Appeal filed under Paragraph 6.

For purposes of these Procedures, an "adverse determination" shall mean determination of a Claim resulting in a denial, reduction, or termination of a benefit under a Plan, or the failure to provide or make payment (in whole or in part) of a benefit or any form of benefit under a Plan. Adverse determinations shall include denials, reductions, etc. based upon the Claimant's lack of eligibility to participate in a Plan. Decisions rendered by the Claims Manager under these Procedures shall be reported to the Plan Administrator periodically, which report shall include reference to the applicable governing Plan provision(s) and, where applicable, reference to prior determinations of claims involving similarly situated claimants.

6. Appeal of Claim Denials

A Claimant who has received an adverse determination of all or part of a Claim shall have 60 days from the date of such receipt to appeal the denial. An "Appeal" must be in writing and delivered to the Claims Manager at the address listed in Paragraph 3 above. An Appeal will be considered timely only if actually received by the Claims Manger within the 60-day period or, if sent by mail, postmarked within the 60-day period. All timely Appeals shall receive a full and fair review by the Senior Vice President and Vice Dean of Human Resources (the "Appeals Reviewer").

7. Consideration of Appeals

The Appeals Reviewer shall make an independent decision as to the Claim based on a full and fair review of the record. The Appeals Reviewer shall take into account in its deliberations all comments, documents, records and other information submitted by the Claimant, whether submitted in connection with the Appeal or in connection with the original Claim, and may, but need not, hold a hearing in connection with its consideration of the Appeal. The Appeals Reviewer shall consider an Appeal within a reasonable period of time, but not later than 60 days after receipt of the Appeal, unless the Appeals Reviewer determines that special circumstances (such as the need to hold a hearing), require an extension of time. If the Appeals Reviewer determines that an extension of time is required, he or she will cause written notice of the extension, including a description of the circumstances requiring an extension and the date by

which the Appeals Reviewer expects to render the determination on review, to be furnished to the Claimant prior to the end of the initial 60-day period. In no event shall an extension exceed a period of 60 days from the end of the initial period; provided, that in the case of any extension of time required by the failure of the Claimant to submit information necessary for the Appeals Reviewer to consider the Appeal, the period of time in which the Appeal is required to be considered under this Paragraph 7 shall be tolled from the date on which notification of the extension is sent to the Claimant until the date on which the Claimant responds to the Appeals Reviewer's request for additional information.

8. Resolution of Appeal

Notice of the Appeals Reviewer's determination with respect to an appeal shall be communicated to the Claimant in writing by registered or certified mail posted within the time period described in Paragraph 7 above. If adverse, shall include:

- The specific reason or reasons for the adverse determination,
- Reference to the specific Plan provisions on which the adverse determination was based, and
- Reference to and a copy of these Procedures, so as to provide the Claimant with a description of the Claimant's rights regarding documentation as described in Paragraph 9, and a statement of the Claimant's rights under Section 502(a) of ERISA to bring a civil action with respect to the adverse determination.

9. Certain Information

In connection with the determination of a Claim or Appeal, a Claimant may submit written comments, documents, records and other information relating to the Claim and may request (in writing) copies of any documents, records and other information relevant to the Claim. An item shall be deemed "relevant" to a Claim if it:

- Was relied upon in determining the Claim,
- Was submitted, considered or generated in the course of making such determination (whether or not actually relied upon), or
- Demonstrates that such determination was made in accordance with governing Plan documents (including, for this purpose, these Procedures) and that, where appropriate, Plan provisions have been applied consistently with similarly situated Claimants.

The Plan Administrator shall furnish free of charge copies of all relevant documents, records and other information so requested; provided, that nothing in these Procedures shall obligate New York University, NYU Langone Hospitals, NYU Langone Health System, NYU Langone MSO, Inc., the Plan Administrator, or any person or committee to disclose any document, record or information that is subject to a privilege (including, without limitation, the attorney-client privilege) or the disclosure of which would, in the Plan Administrator's judgment, violate any law or regulation.

10. Rights of a Claimant Where Appeal is Denied

Where a Claimant's Appeal is denied, the Claimant may be entitled to bring suit under Section 502(a) of ERISA. The Claimant's actual entitlement, if any, to bring suit and the scope of and other rules pertaining to any such suit shall be governed by, and subject to the limitations of, applicable law, including ERISA. By extending to an employee or former employee the right to file a Claim under these Procedures, neither New York University, NYU Langone Hospitals, NYU Langone Health System, NYU Langone MSO, Inc., nor any person or committee appointed as Plan Administrator acknowledges or concedes that such individual is a "participant" in a Plan within the meaning of the Plan or ERISA, and reserves the right to assert that an individual is not a "participant" in any action brought under Section 502(a).

11. Special Rules Regarding Disability

This Paragraph 11 and Appendix A set forth special rules applicable to certain claims regarding disability. Certain benefits under one or more of the Retirement Plans are contingent upon an individual's being "disabled," incurring a "disability," or otherwise becoming entitled to a disability benefit under the federal Social Security Act or a separate disability plan maintained by New York University, NYU Langone Hospitals, NYU Langone Health System, or NYU Langone MSO, Inc. Where a Claim requires a determination of whether an individual would be entitled to disability benefit payments under a separate long-term disability plan maintained by New York University, NYU Langone Hospitals, NYU Langone Health System, or NYU Langone MSO, Inc., and such individual is not actually a participant in such disability plan, the additional rules set forth in Appendix A to these Procedures shall apply to the Claim, notwithstanding any provision of the Procedures to the contrary. However, where disabled status is based upon actual entitlement to benefits under a separate disability plan or program (including the federal Social Security Act) in which the individual participates or is otherwise covered, the determination of such status for purposes of the Plans shall be made under such separate disability plan or program (rather than Appendix A of this document), and any claims or disputes as to disabled status under such plan or program shall be resolved in

accordance with the procedures established for that purpose under the separate disability plan or program, with the Plan Administrator solely having the discretion to determine the relevant disability plan or program and processing any notifications of determinations resulting from such disability plan or program.

12. Authorized Representation

A Claimant may authorize an individual to represent him or her with respect to a Claim or Appeal made under these Procedures. Any such authorization shall be in writing, shall clearly identify the name and address of the individual, and shall be delivered to the Manager of Benefits at the address listed in Paragraph 3 above. Upon receipt of a letter of authorization, all parties authorized to act under these Procedures shall be entitled to rely on such authorization, until similarly revoked by the Claimant. While an authorization is in effect, the "Claimant" as used in these Procedures shall include his or her authorized representative for purposes of all notices and communications to be provided under these Procedures.

13. Form of Communications

Unless otherwise specified above, any Claim, Appeal, notice, determination, request, or other communication made under these Procedures shall be in writing, with original signed copy delivered by hand or first class mail (including registered or certified mail). A copy or advance delivery of any such Claim, Appeal, notice, determination, request, or other communication may be made by electronic mail or facsimile. Any such electronic or facsimile communication, however, shall be for the convenience of the parties only and not in substitution of a written communication to be mailed or delivered under these Procedures, and receipt or delivery of any such Claim, Appeal, notice, determination, request, or other written communication shall not be considered to have been made until the actual posting or receipt of original signed copy, as the case may be.

14. Reliance on Outside Counsel, Consultants, etc.

Subject to Paragraph 11, the Claims Manager and the Appeals Reviewer may rely on or take into account advice or information provided by such legal, accounting, actuarial, consulting or other professionals as may be selected in determining a Claim or Appeal, including those individuals and firms described above that may render advice to New York University, NYU Langone Hospitals, NYU Langone Health System, NYU Langone MSO, Inc. or its affiliates, or one or more of the Plans from time to time.

15. Amendment of Procedures; Interpretation

These Procedures may be modified at any time and from time to time by action of the Plan Administrator and shall be deemed automatically modified to incorporate any requirement attributable to a change in the applicable Department of Labor regulations. The Plan Administrator shall have complete discretion to interpret and apply these Procedures, including, for purposes of applying these Procedures, such regulations. Further, nothing in these Procedures shall be construed to limit the discretion of the Plan Administrator or its designee to interpret the Plans or, subject to the right of appeal of an adverse determination, the finality of the decision of the Plan Administrator or its designee, all as set forth in the Plans.

Appendix A

Special Rules Regarding Certain Disability Claims

Pursuant to Paragraph 11 of the foregoing "Claims Procedures," the following special rules supplement the Claims Procedures and apply only in the case of a Claim or Appeal (a "Disability Claim") which requires a determination of whether an individual is disabled and such individual is not otherwise eligible for benefits under a separate long-term disability plan maintained by New York University, NYU Langone Hospitals, NYU Langone Health System, or NYU Langone MSO, Inc., or otherwise entitled to disability benefits under titles II or XVI of the federal Social Security Act (each a "Disability Plan"). If a Claimant is otherwise eligible for benefits under a Disability Plan, than any determinations of whether an individual is disabled for purposes of any Retirement Plan shall be made under the relevant claims and review procedures of the Disability Plan (and not this Claims Procedure). Upon written notification of the final determination of a Disability Plan, the Claims Manager shall treat the Claimant as "disabled" for purposes of each applicable Retirement Plan.

Reliance on Outside Counsel, Consultants, etc.

The Plan Administrator and Claims Manager will ensure that all Disability Claims are adjudicated in a manner designed to ensure independence and impartiality. Accordingly, decisions regarding retention, compensation, termination, promotion or other similar matters with respect to any individual consulted on the Disability Claim will not be made based upon the likelihood that the individual will support the denial of benefits.

Time to Process Claims

The Claims Manager will process and inform the Claimant of the determination with respect to Disability Claims in accordance with Paragraphs 4 and 5 of the Claims Procedures, except that a period of 45 days shall apply instead of the initial 90 days in which to process and determine the Disability Claim. This period may be extended initially by the Claims Manager for 30 days if the Claimant is notified before the end of the original 45-day period that the extension is necessary due to matters beyond the control of the Plan Administrator or Claims Manager. This 30-day extension period may be extended by the Claims Manager for an additional 30 days if the Claimant is notified before the end of the first 30-day extension that the extension is necessary due to matters beyond the control of the Plan Administrator or Claims Manager. Any notice of an extension will explain the reason for the extension, when the Claims Manager expects to rule on the Disability Claim, the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the Disability Claim, and any additional information needed to resolve those issues. If the Claimant is informed that he or she needs to provide additional information necessary to resolve Disability Claim issues, the Claimant will have 45 days from the date he or she receives the extension notice to provide the additional information.

Determination of Claim; Notice of Determination

The Claims Manager may require and rely upon the written report or certification from a licensed physician selected or approved by the Claims Manager. In addition to the requirements of Paragraph 5 of the Claims Procedures, any written notice of an adverse determination of a Disability Claim will include a copy of any internal rules, guidelines, protocols, or other similar criteria that were relied upon in the decision-making, or a statement that the determination was based on the applicable items mentioned above, and that copies of the applicable items will be provided, free of charge, upon the Claimant's request.

In addition, if the adverse determination is based on a medical necessity, experimental treatment or similar exclusion or limit, the notice will contain an explanation of the scientific or clinical judgment used in the determination, applying the terms of the relevant long-term disability plan to the Claimant's medical circumstances, or a statement that such explanation will be provided, free of charge, upon the Claimant's request. If the Claims Manager disagreed with the views presented by the Claimant of health care professionals who treated the Claimant, vocational professionals who evaluated the Claimant, medical or vocational experts who advised the Plan (without regard to whether the advice was relied on), or by the Social Security Administration, the written notice will also contain a discussion of such information and the basis for each such disagreement.

Information Provided in a Culturally and Linguistically Appropriate Manner

Each notice or communication relating to a Disability Claim will provide oral and written guidance in each applicable non-English language (as determined by the Department of Labor's periodic guidance) as well as a statement (in each such applicable non-English language) as to how such assistance can be obtained.

Appeal of a Claim Denial

Notwithstanding Paragraph 6 of the Claims Procedures, a Claimant who has received an adverse determination of all or part of an initial Disability Claim shall have

180 days from the date of such receipt to appeal the denial (a "Disability Appeal"). Notwithstanding Paragraph 7 of the Claims Procedures, review of a Disability Appeal will be conducted by the Appeals Reviewer without deference to the initial adverse benefit determination by the Claims Manager. The Claimant shall be provided an opportunity to submit written comments, documents, records, and other information relating to the Disability Claim. If the adverse determination was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Appeals Reviewer shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in connection with the initial claim denial (and who is not the subordinate of such an individual). Any medical or vocational experts whose advice was obtained will be identified, without regard to whether the advice was relied upon in making the benefit determination. Notwithstanding Paragraphs 7 and 8 of the Claims Procedures, the Appeals Reviewer shall consider and communicate its determination with respect to a Disability Appeal within a reasonable time, but not later than 45 days after receipt of the Disability Appeal, unless special circumstances require an extension for processing, in which case a decision will be made within a 45 day extension period. However, sufficiently prior to such date as to allow a response to be considered before a decision is rendered, the Appeals Reviewer shall provide the Claimant, free of charge, with any (1) new or additional rationale and (2) new or additional evidence considered, relied upon, or generated by the Claims Manager, Appeals Reviewer, insurer, or other person making the benefit determination (or at the direction of the plan, insurer or such other person) in connection with the Disability Claim.

Resolution of Appeal

In addition to the information required by Paragraph 8 of the Claims Procedures, any written notice of an adverse determination of a Disability Appeal by the Appeals Reviewer will include a description of any specific internal rules, guidelines, protocols, or other similar criteria that were relied on in making the decision, or a statement that the decision was based on the applicable items mentioned above, and copies of the applicable items will be provided, free of charge, upon the Claimant's request. If the Appeals Reviewer disagreed with the views presented by the Claimant of health care professionals who treated the Claimant, vocational professionals who evaluated the Claimant, medical or vocational experts who advised the Plan (without regard to whether the advice was relied on), or by the Social Security Administration, the written notice will contain a discussion of such information and the basis for each such disagreement. In addition, if the adverse determination with respect to the Disability Appeal is based on a medical necessity, experimental treatment or similar exclusion or limit, the notice will contain an explanation of the scientific or clinical judgment used in the determination, applying the terms of the relevant long-term disability plan to the Claimant's medical circumstances, or a statement that such explanation will be provided, free of charge, upon the Claimant's request.