

SUMMARY PLAN DESCRIPTION
for the
UNIVERSITY OF ROCHESTER
WELFARE BENEFITS PLAN

This document, together with the insurance policies, separate benefit-specific summaries, enrollment materials, and similar documents used to provide and describe the health and welfare benefits constitute the summary plan description for the University of Rochester Welfare Benefits Plan (the “Plan”). Benefits under the Plan are provided to eligible employees of the University of Rochester (the “Employer”). This SPD reflects the terms of the Plan in effect as of January 1, 2023.

Name, Plan Number and Plan Year of Benefits Covered by this Summary

This summary includes all of the benefits listed in the following chart for purposes of consolidated disclosure and convenience. Each benefit plan is reported separately for ERISA reporting purposes, as noted.

Plan Name	Plan Number	Plan Year
LTD Plan for Faculty and Staff of the University of Rochester	504	7/1 to 6/30
Group Life Insurance Plan for Faculty and Staff of the University of Rochester	505	1/1 to 12/31
Travel Accident Insurance for Faculty and Staff of the University of Rochester	506	6/11 to 6/10
LTD Plan for Staff of University of Rochester who are Members of SEIU	512	10/1 to 9/30
Severance Pay for Staff of the University of Rochester	514	7/1 to 6/30
Employee Assistance Program for Faculty & Staff of the University of Rochester	515	1/1 to 12/31
Health Care Plans for Faculty and Staff of the University of Rochester (includes Vision benefits)	517	1/1 to 12/31
Dental Plans for Faculty and Staff of the University of Rochester	518	1/1 to 12/31
Long-Term Care Plan for Faculty and Staff of the University of Rochester	519	1/1 to 12/31
Long-Term Disability for Residents of the University of Rochester	521	7/1 to 6/30

Legal Services Plan of the University of Rochester	522	1/1 to 12/31
University of Rochester Retiree Health Reimbursement Arrangement	523	1/1 to 12/31

More information about the providers of these benefits is found in Exhibit A. Exhibit A may be amended by the Plan Administrator from time to time, without the need for formal amendment to the Plan. More information about the specific benefits provided is found in the separate insurance certificates or other benefit-specific summaries for that specific benefit put together by the Employer, the insurance company or third party administrator for that benefit.

In general, the summary for each benefit describes the specific benefits that are provided by the insurance company or third party administrator, including any terms and conditions associated with those benefits; the annual enrollment information provided before the beginning of each Plan Year describes eligibility, cost sharing and other matters that relate to the terms and conditions of participation in a particular Plan Year; and this document describes supplemental information relevant to all Plan benefits; e.g., information about the Employer, the classes of employees eligible to participate and certain legally-required statements about your benefits rights.

The aggregate information provided in the insurance certificates, separate benefit-specific summaries, the annual enrollment materials, and similar documents used to provide and describe the health and welfare benefits, are intended to constitute the summary plan description for the covered benefits. The Plan document, a copy of which may be obtained by contacting the Office of Human Resources, is the controlling legal document should any dispute arise over the terms and conditions of this Plan.

Name of Plan Sponsor

University of Rochester
60 Corporate Woods, Suite 310
PO Box 270453
Rochester, NY 14627-04531
Telephone Number: (585) 275-2084

Employer Tax Identification Number: 16-0743209

Plan Administrator and Agent for Service of Legal Process

Vice President and Chief Human Resources Officer
University of Rochester
60 Corporate Woods, Suite 310
PO Box 270453
Rochester, NY 14627-0453
Telephone Number: (585) 275-2084

The Plan Administrator determines, in its sole discretion, your eligibility to participate in this Plan and the specific benefit, and, for benefits managed internally (if any), whether benefits are payable for a claim. For insured benefits, the insurer determines whether benefits are payable under its policy or contract for a claim in its sole discretion. For self-insured benefits, the third party administrator determines whether benefits are payable in its sole discretion. The Plan Administrator has the discretion to administer and interpret all aspects of the Plan not set forth in

an insurance policy. The Plan Administrator may delegate its authority to one or more persons or organizations and such delegation will include full discretion unless such discretion is restricted by the delegation.

Qualified Medical Child Support Orders (QMCSOs)

The Plan Administrator has the sole responsibility to determine whether a medical child support order is “qualified” under the terms of ERISA, though the Plan Administrator may delegate this responsibility to an insurer or third-party administrator. All such orders must be submitted to the Plan Administrator (preferably in draft form before being sent to the court for signature to minimize the chances of your having to return to court if the order is not qualified). The Plan Administrator will respond within 90 days to all affected parties on whether the order qualifies (or will qualify when signed by a court). You may obtain a copy of the procedures used for processing an order, free of charge, from the Plan Administrator.

Type of Administration

As set forth in Exhibit A, some benefits under the Plan are self-funded, and other benefits are fully insured. The self-funded benefits are third-party administered. Self-funded claims are paid from the Employer’s general assets, and the third-party administrator arranges for payment of such claims.

The insured benefits are insurer administered. The insurance companies, not the Employer, are responsible for paying claims with respect to the insured benefits.

Eligibility

An otherwise eligible employee or retiree of the Employer is covered by a specific benefit only if he or she falls within one or more categories of covered employees or retirees as described for that specific benefit as set forth in Exhibit B. Exhibit B may be amended by the Plan Administrator from time to time, without the need for formal amendment to the Plan. A participating employee may be referred to as a “participant.”

Notwithstanding the foregoing, the following persons generally are not eligible to participate in this Plan: (1) leased employees; (2) union employees, unless the relevant collective bargaining agreement provides for their participation or the Employer voluntarily arranges for their participation; (3) independent contractors (including persons treated by the Employer as independent contractors) even if a court or agency should determine such persons to be “common law employees”; or (4) agency contract employees. Additionally, a benefit does not cover an individual who has executed an agreement pursuant to which the individual has waived his/her right to participate in the benefit or has acknowledged that he/she is not entitled to participate in the benefit.

Employees remain eligible for benefits (including any cost-share subsidy provided by the Employer, if applicable) during a leave of absence in accordance with the benefit, Employer’s handbook and/or similar policies and as set forth in the leave of absence policies. Additional continuation coverage at the employee’s own expense following the loss of benefits may be available under COBRA or USERRA, as described in this document.

Spouses, dependents and/or domestic partners may also be eligible to be covered by some of the benefits if so provided in the relevant benefit summary, document, certificate of insurance, and/or enrollment materials, and as set forth in Exhibit B. In order to be eligible, domestic partners must also qualify for benefits in accordance with the University’s domestic partner criteria and file a

Certification of Domestic Partner Status with the University. Questions relating to Plan eligibility shall be decided by the Plan Administrator and shall be decided pursuant to the claims procedures set forth in Exhibit C.

If you continue active employment when you reach age 65, your University Health Care Plan remains the primary coverage, with Medicare as the secondary payer. Certain employees remain eligible for benefits upon retirement from the University as set forth in Exhibit B. When you retire, transfer to an ineligible or inactive (e.g., LTD) status, or terminate your University employment, your primary coverage will become Medicare (Parts A and B). Note that federal law does not recognize a domestic partner as a “spouse” for purposes of delaying the Medicare enrollment through a special enrollment period; your domestic partner should enroll during their initial Medicare enrollment period.

When a retiree and/or eligible dependent becomes eligible for Medicare during retirement (or at retirement if already eligible for Medicare coverage at the time of retirement), coverage under the active University Health Care Plans ends and the coverage is canceled. If eligible for retiree benefits, the Medicare-eligible individual(s) must complete an application for enrollment in one of the Medicare-eligible plans offered through the Via Benefits Marketplace if they wish to participate in the Retiree Health Reimbursement Arrangement through the University. Enrollment applications for Medicare-eligible plans generally must be completed prior to the effective date of coverage. Applications for enrollment are available through the Via Benefits Marketplace.

Please note, since the Retiree Health Reimbursement Arrangement available to University of Rochester Medicare-eligible retirees (and their covered dependents) requires enrollment in medical plans through Via Benefits Marketplace that either supplement or coordinate with Medicare, retirees (and their covered dependents) must apply for original Medicare (Parts A and B) coverage prior to their 65th birthday. The Social Security Administration generally recommends that you contact Social Security three months before you turn age 65.

A separate brochure explains the Retiree Health Reimbursement Arrangement available to Medicare-eligible retirees, Medicare-eligible spouses/domestic partners, and Medicare-eligible children. This brochure can be viewed at www.rochester.edu/working/hr/benefits/retirement/post-retirement/.

Enrollment and Entry Date

Participation in a specific benefit is conditioned on completion of the relevant enrollment process and any enrollment materials, an employee’s or retiree’s payment of the required cost share, if any, of the benefit’s cost and the satisfaction of any other relevant terms and conditions imposed by the Plan Administrator, the specific benefit, the insurance company, or the third-party administrator.

An initial enrollment period shall occur at or near an employee’s hire date. Thereafter, enrollment may occur during an annual enrollment period or as otherwise permitted under the applicable Section 125, “cafeteria” plan which allows employees to pay for benefits on a pre-tax basis. If an employee fails to enroll during an initial enrollment period or annual enrollment period, as applicable, the employee will be deemed to have not elected to participate in any benefit (except participation in any benefit that is automatic and the cost of which is fully paid by the Employer).

The entry date for initial commencement of participation in a specific benefit is described in Exhibit A. Enrollment during an annual enrollment period will be effective as of the following first day of the Plan Year for each specific benefit.

Costs of Plan and Ownership of Rebates

Any benefit cost share is specified in the annual enrollment materials. The Employer pays the balance of any premiums and administrative expenses out of its general assets. Where applicable, employee premiums are paid on a pre-tax basis through the cafeteria plan. Neither the Plan nor any of the benefits offered through it have a trust.

To the extent any Program generates Medical Loss Ratio or other rebates, those rebates shall be attributed to the Employer's share of the premiums and shall not be considered plan assets attributable to employee premium contributions, except to the extent otherwise required by ERISA or other applicable law.

Amendment and Termination

The Employer, the Senior Vice President of Administration and Finance, the Plan Administrator, and the Director, University Benefits shall each have and retain the right, subject to the terms of any program, to make any amendment to this Plan and the terms of any program at any time, including the right to terminate this Plan or to adopt or terminate any program at any time. The Employer, the Senior Vice President of Administration and Finance, the Plan Administrator and/or the Director, University Benefits each may also amend, modify or terminate current or future retiree coverage, if any, offered under any program. The right to amend or modify a program includes the right to change the eligibility, benefits and cost sharing provisions under a program.

An official publication to employees issued by the University of Rochester Benefits Office, including, but not limited to, open enrollment materials or the University of Rochester Health Program Guide, which constitutes a Summary of Material Modifications with respect to a program, shall be deemed to be an amendment to the program made by the Senior Vice President of Administration and Finance, the Plan Administrator, and/or the Director, University Benefits.

Subrogation

If you or a covered family member is injured or ill and a third party is found liable, that third party will be liable for any expenses incurred by the Plan as a result of the injury. You will be responsible for reimbursing the Plan, in first priority, for the applicable expenses paid by it and to cooperate fully to perform all actions necessary to secure the Plan's rights of recovery. If payment by a third party is made or is expected to be made in the future, the Plan will process claims and will seek reimbursement of funds through the recovery process from either you, the person(s) responsible for the injury and/or that person's insurer.

Note that accidents that occur in someone else's home are typically covered under that person's homeowner's policy. If you require treatment as a result of an accident in someone else's home, you should seek reimbursement under his or her insurance policy.

HIPAA Privacy and Security Practices

Under the Health Insurance Portability and Accountability Act (HIPAA), the Plan Administrator and its contracted vendors (Business Associates) are required to follow specified procedures regarding the protection and transmission of your protected health information (PHI). The benefits covered under the HIPAA Privacy and Security Practices include group health benefits under the Plan.

The Plan has updated its contracts and procedures to ensure compliance with this act. Upon eligibility to the plan, and at least every three years thereafter, you will be provided with a Notice

of Privacy Practices outlining yours and the Plan's rights and obligations under HIPAA. Should you require additional information, or to obtain a copy of the Notice of Privacy Practices, you may contact your Human Resources Representative. You can also obtain a copy of the Notice of Privacy Practices online at http://rochester.edu/working/hr/benefits/library/privacy_practice.pdf.

Plan's Right to Recover Overpayments and Other Erroneous Payments

To the extent permitted by law, if, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a participant or a dependent, the participant or the dependent shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the insurance companies, the third party administrator, the Plan Administrator or the Employer (or designee) may recover that incorrect payment, whether or not it was made due to the insurance companies', third party administrator's or the Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party. As may be permitted in the sole discretion of the insurance company, third party administrator, or the Plan Administrator (or its designee), the refund or repayment may be made in one or a combination of the following methods: (a) in the form of a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator, insurance company, or third party administrator. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

Claims Procedure

All claims for benefits under a specific benefit shall be submitted in accordance with the terms of that benefit and shall be subject to the claims review procedure for that benefit. However, if the particular issue on which a claim is based does not relate to any benefit, or if the benefit's claims procedures do not comply with ERISA, then the claim procedures in Exhibits D and E apply or supplement the benefit's claims procedures, as appropriate.

Statute of Limitations

All claims for benefits must be submitted by the claims filing deadline specified under the rules for a particular benefit. If the benefit does not specify a filing deadline, then claims must be submitted within one year from the date the services relating to the claim were performed or the event that gave rise to the benefit occurred. This requirement may be waived by the Plan if, through no fault of the participant or dependent, the claim is filed after the deadline but is filed as soon as practicable and within a reasonable time period, given the particular circumstances. Except in the case of legal incapacitation, late claims will not be accepted if they are filed more than two years from the date the services relating to the claim were performed or the event that gave rise to the benefit occurred.

A claimant may not commence a judicial proceeding against any person, including the Plan, a Plan fiduciary, the Plan Administrator, the Plan Sponsor, or any other person, with respect to a claim for benefits without first exhausting the applicable claims procedures. A claimant who has exhausted these procedures and is dissatisfied with the decision on appeal of a denied claim may bring an action under Section 502 of ERISA in the United States District Court for the Western District of New York to review the Plan Administrator's decision on appeal but only if such action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the decision on appeal.

A claimant that seeks to commence a lawsuit or legal action against any person, including the Plan, a Plan fiduciary, the Plan Administrator, the Plan Sponsor, or any other person or committee, in connection with the Plan must do so in the United States District Court for the Western District of New York. Such United States District Court is the sole forum for a claimant bringing a lawsuit.

Maternity and Newborn Infant Coverage Statement

Under federal law, none of the group health plans offering maternity or newborn infant coverage may 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 normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not in excess of the foregoing periods. This requirement does not prevent an attending physician or other provider, in consultation with the mother, from discharging the mother or newborn child prior to the expiration of the applicable minimum period.

Continuation Coverage under COBRA

Health benefits under this Plan are subject to COBRA continuation coverage. In the event of a COBRA qualifying event, affected employees and their beneficiaries will be given a notice of entitlement to elect continuation coverage for periods that can range up to 18, 29 or 36 months depending on the qualifying event. An election to take continuation coverage must be made within 60 days of this notice and persons making this election must pay the full amount of the premiums and may be charged a 2 percent administrative charge. The initial premium is due within 45 days of returning a notice electing coverage and must cover the entire premiums due from the date your coverage otherwise would have ceased. A participant or affected dependent must notify the Plan Administrator within 60 days of divorce, legal separation or a dependent's no longer satisfying the age or other conditions of eligibility in order for the COBRA administrator to send out a qualifying event notice and other materials to affected persons. More detailed information on COBRA will be found in the benefit materials and in the COBRA general and qualifying event notices.

Surviving Spouses and dependents of active employees who were employed by the Employer for at least five (5) years at the time of the employee's death shall be entitled to receive twelve (12) months of subsidized COBRA coverage. Such subsidized COBRA coverage shall be subsidized by the Employer at a rate which results in the cost of COBRA coverage for the surviving Spouse or dependent being equal to the employee's share of the premium for active coverage at the time of the employee's death. Following the end of the twelve (12) month COBRA subsidization period, surviving Spouses or dependents shall be charged the entire premium for COBRA coverage.

Continuation Coverage under USERRA

If you are taking a military leave covered by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), you have additional continuation coverage rights. If the leave is for less than 31 days, you and your dependents have the right to continue coverage during military leave on the same terms and conditions as if you had remained in active employment. If the leave is 31 days or more, you and your dependents may elect to continue coverage for up to 24 months (instead of 18). The premium for the 24 months is the full amount of the premium plus a 2 percent administrative charge.

Continuation Coverage under State Law

State law may also provide continuation and/or conversion coverage.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage (or if the employer stops contributing toward your or your dependents' other coverage), you may in the future be able to enroll yourself or your dependents in this plan, 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 dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you and/or your dependents are covered under Medicaid or a state Child Health Insurance Program (CHIP) and lose eligibility for such coverage, you may be able to enroll yourself or your dependents who lost such coverage in a health insurance benefit, provided that you request enrollment within 60 days after the loss of coverage. Likewise, if you and/or your dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself or your dependents who become eligible for premium assistance in a health insurance benefit, provided that you request enrollment within 60 days after the date you are determined to be eligible for premium assistance. If your dependent child is receiving Medicaid or CHIP premium assistance toward the cost of plan benefits, you may also be able to disenroll the child from a health insurance Program and enroll the child in and receive child health assistance under the state child health plan, effective on the first day of any month for which the child is eligible for premium assistance, to the extent required by law.

Women's Health and Cancer Rights Act

All group health plans and their insurance companies or health maintenance organizations that provide coverage for medical and surgical benefits with respect to a mastectomy must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. Group health plans, insurance companies, and HMOs may impose deductible or coinsurance requirements for reconstructive surgery in connection with a mastectomy, but only if the deductible and coinsurance are consistent with those established for other benefits under the plan or coverage.

Designation of Primary Care Providers and/or OB/GYN

If the health insurance option under which you are enrolled requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the health insurance option under which you are enrolled designates a primary care provider automatically, until you make this designation, one will be designated for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your medical/dental plan customer service department.

If the health insurance option under which you are enrolled require or allow for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If the health insurance option under which you are enrolled provides coverage for obstetric or gynecological care and requires the designation of a primary care provider, you do not need prior authorization from the Plan or from any other person (including a primary care provider) in order

to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your health plan customer service department.

Lifetime Limits

The health insurance component of the Plan does not impose a lifetime limit on essential health benefits (as defined in guidance and regulations issued by the Department of Health and Human Services).

Antiassignment Provision

The right of a participant to receive benefits or reimbursements under this Plan and the underlying programs is personal to the participant and is not assignable in whole or in part to any person, including, without limitation, any medical service provider, except with the written consent of the Plan Administrator. All benefits and benefit claims under this Plan and the underlying programs shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable hereunder, shall be void. The Plan shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder. A direct payment by the Plan to a person or entity that provides medical services to a Plan participant shall not be treated as a waiver of this provision. Additionally, a medical service provider shall not have any standing to bring a claim for benefits against the Plan, a Plan fiduciary, the Plan Administrator, or the Employer with respect to the services it provides to a Plan participant.

No Guarantee of Employment

Nothing contained in this Plan shall be construed as a contract of employment between the Employer and any employee, or as a right of any employee to be continued in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its employees, with or without cause.

When Coverage Ends

Except to the extent otherwise provided in the benefit materials, Participation in the Plan and/or any benefits offered under the Plan cease on the date on which:

- The Employer terminates the Plan or the benefits(s) in which the participant participates;
- Coverage under the benefits terminates or the insurer ceases providing benefits due to bankruptcy;
- A participant or dependent no longer meets the eligibility requirements for the Plan or a benefit;
- A participant fails to make required contributions;
- The participant drops coverage for the employee or dependent(s);

- The participant's or dependent's benefits are terminated due to fraud or intentional misrepresentation against the Plan or benefit;
- The participant terminates employment with the Employer;
- The participant retires (except where the participant is eligible for retiree benefits as a Retiree);
- The participant retires but is ineligible for retiree benefits due to Medicare eligibility or otherwise;
- The participant dies.

The Employer may elect to extend coverage for benefits until the last day of the month in which any of the events described in "When Coverage Ends" occurs, if required by law or in accordance with the terms of specific benefit and/or agreed to by the insurance company, and if coverage is so extended on a uniform and consistent basis to a non-discriminatory class of employees or dependents.

Miscellaneous Plan Provisions

- To the extent permitted by law, the Plan reserves the right to terminate a covered participant's benefits, deny future benefits, take legal action against a covered participant, and/or set off from any future benefits the value of benefits the Plan has paid relating to inaccurate information or misrepresentations provided to the Plan, in the case of any Plan participant who obtains benefits wrongfully due to intentional misrepresentation or fraud.
- To the extent permitted by law, the Employer reserves the right to take any employment-related actions, including termination of employment, in the case of any employee participant who obtains benefits wrongfully due to intentional misrepresentation or fraud.
- The Employer makes no representation or warranty with respect to the quality or sufficiency of the services or supplies provided by others under the Plan or its constituent programs.
- The Employer makes no separate promise to pay benefit claims for any specific benefit provided by an insurer or third party administrator. Participants are entitled to receive only those benefits the insurer or third party administrator agrees to pay.
- The Employer makes no representation or warranty with respect to the tax treatment of any benefits provided by the Plan.
- No provision of this Plan or any specific benefit shall be deemed to be waived unless the purported waiver is in writing and is signed.
- Participants have no vested rights to benefits under the Plan or its specific benefits, and benefits may be reduced or terminated at any time.

ERISA Rights Statement

Participants in the Plan have certain legal rights under Federal law. The U.S. Department of Labor requires that you be informed of these rights in the following form:

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

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all Plan documents, including insurance contracts, and a copy of the latest annual report (Form 5500 series) (should it become necessary for the Plan to file a Form 5500), filed by the plan with the U.S. Department of Labor.
- Obtain upon written request to the Plan Administrator copies of documents governing the administration of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) (should it become necessary for the Plan to file a Form 5500) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Continue health care coverage for yourself, spouse or dependent if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation rights.
- Receive a summary of the Plan's annual financial report (if a Form 5500 is filed). The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report (if a Form 5500 is filed).

Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and dependents. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health and welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a health and welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the ERISA rights described herein. 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 such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse 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.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any 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 the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**EXHIBIT A
Component Programs of Plan and Entry Date**

Plan Name	Plan Number	Plan Year	Funding	Entry Date
LTD Plan for Faculty and Staff of the University of Rochester***	504	7/1 to 6/30	Insured	The date following one year of service, provided the individual is actively at work on the first employment anniversary.*
Group Life Insurance Plan for Faculty and Staff of the University of Rochester	505	1/1 to 12/31	Insured	For University-Paid Basic Term Life insurance and Basic Accidental Death & Dismemberment (AD&D) insurance, immediately upon appointment/hire. Any Group Universal Life (GUL) insurance is effective on the date you sign the request, if evidence of insurability is not required; otherwise on the date of approval by the carrier.
Travel Accident Insurance for Faculty and Staff of the University of Rochester	506	6/11 to 6/10	Insured	Faculty, staff and their covered dependents are eligible for Travel-Accident Insurance (including medical and travel-related assistance services) immediately upon appointment/hire and are automatically enrolled in coverage.
LTD Plan for Staff of University of Rochester who are Members of 1199 Upstate SEIU	512	10/1 to 9/30	Insured	Regular full-time and part-time (appointed to work at least 17.5 hours or more per week) staff who are members of SEIU 1199 Upstate-SMH and SEIU Local 200 United-River Campus are eligible for Long-Term Disability Insurance upon completion of one year of service with the University.*

Severance Pay for Staff of the University of Rochester	514	7/1 to 6/30	Self-Funded	Staff members with one year or more of University service who are indefinitely laid off may be eligible to receive severance pay. Severance pay will be paid to eligible staff not obtaining other University employment or comparable employment outside the University by the end of the pay period following the effective date of layoff.
Employee Assistance Program for Faculty & Staff of the University of Rochester	515	1/1 to 12/31	Self-Funded	First day of employment.
Health Care Plans for Faculty and Staff of the University of Rochester (includes Vision benefit and retiree health benefit)**	517	1/1 to 12/31	Self-Funded (vision benefit is insured)	<ul style="list-style-type: none"> • Faculty/Staff (new hires and change in employment status eligibility): First day of the month following or coinciding with the date of hire or the date the individual becomes eligible for coverage due to a change in employment status. • Faculty/Staff (all other change in status events): The date of the event or the date the enrollment form is submitted, whichever is later (provided that enrollment forms are submitted within 30 days of the change in status event). • Residents/Fellows (new appointees and change in appointment status eligibility): The appointment start date, provided that enrollment forms are submitted within 30 days of the appointment

				<p>date/change in status.</p> <ul style="list-style-type: none"> • Residents/Fellows (all other change in status events): The date of the event or the date the enrollment form is submitted, whichever is later (provided that enrollment forms are submitted within 60 days of the change in status event). • Vision Benefit: If you enroll by the 15th of the month, coverage will be effective 1st of the following month. If you enroll on the 16th – 30th/31st day of a month, coverage will be effective the 1st day of the second following month.
<p>Dental Plans for Faculty and Staff of the University of Rochester</p>	<p>518</p>	<p>1/1 to 12/31</p>	<p>Self-Funded</p>	<ul style="list-style-type: none"> • Faculty/Staff (new hires and change in employment status eligibility): First day of the month following or coinciding with the date of hire or the date the individual becomes eligible for coverage due to a change in employment status. • Faculty/Staff (all other change in status events): The date of the event or the date the enrollment form is submitted, whichever is later (provided that enrollment forms are submitted within 30 days of the change in status event). • Residents/Fellows (new appointees and change in appointment status eligibility): The appointment start date, provided that

				<p>enrollment forms are submitted within 30 days of the appointment date/change in status.</p> <ul style="list-style-type: none"> • Residents/Fellows (all other change in status events): The date of the event or the date the enrollment form is submitted, whichever is later (provided that enrollment forms are submitted within 60 days of the change in status event).
Long-Term Care Plan for Faculty and Staff of the University of Rochester	519	1/1 to 12/31	Insured	This LTC Plan is frozen to new entrants.
Long-Term Disability for Residents of the University of Rochester	521	7/1 to 6/30	Insured	Immediately upon appointment/hire, though you would not receive LTD benefits unless you complete the 180-day elimination period (short-term disability period).
Legal Services Plan of the University of Rochester	522	1/1 to 12/31	Insured	If you enroll by the 15th of the month, coverage will be effective 1st of the following month. If you enroll on the 16th-30th/31st, coverage will be effective 1st of the second following month.
University of Rochester Retiree Health Reimbursement Arrangement	523	1/1 to 12/31	Self-insured – Annual funding in January for existing retirees	New retirees are eligible the first of the following month after retirement and their benefits are prorated based on the remaining months in the year. Eligibility ceases for retirees returning to active or temporary employment.

*The one-year waiting period is waived for individuals who apply for coverage within three (3) months after leaving another employer-sponsored long-term disability plan which provided income benefits for at least five years during disability.

**Gallagher for Active Post-docs are fully-insured and insurer administered.

***Certain Senior Executives are eligible for LTD benefits in lieu of those generally provided to Faculty and Staff.

**EXHIBIT B
Eligibility**

Subject to the eligibility definitions set forth in this exhibit, the following eligibility shall apply to the benefits provide under this SPD:

Plan Name	Program Options	Active 1199 SEIU & SEIU Local 200 Union ¹	Active Union (IUOE, URPSOA, Teamsters Local Union No. 118) ¹	Active Full-Time or Part-Time Non-SEIU Union Faculty / Staff	LTD (Union/non-Union)	Active Residents/Fellows	Active Post-Docs	Retirees
LTD Plan for Faculty and Staff of the University of Rochester	N/A	No	Yes	Yes	N/A – In claim status	No	No	No
Group Life Insurance Plan for Faculty and Staff of the University of Rochester	Basic Group Life Insurance	No	Yes	Yes	May continue if enrolled when LTD begins	Yes	No	Yes, if eligible under the terms of the insurance policy
	Group Universal Life Insurance (including spouse/domestic partner life and child life insurance)	No	Yes	Yes	May continue if enrolled when LTD begins	Yes	No	Yes, if eligible under the terms of the insurance policy
	Group Optional AD&D	No	Yes	Yes	May continue if enrolled when LTD begins	Yes	No	Yes, if eligible under the terms of the insurance policy
	Group Life and AD&D Insurance for University of Rochester Postdoc Scholar Benefit Program	No	No	No	No	No	Yes ²	No
	University of Rochester Personnel Policy/Procedure 119 Death Benefit Gratuity	No	Yes	Yes	Yes	No	Yes	No
Travel Accident Insurance for Faculty and Staff of the University of Rochester	N/A	Yes	Yes	Yes	No	Yes	Yes	No

¹ Individuals covered by collective bargaining agreements receive benefits in accordance with those agreements. Copies of those agreements are available upon written request.

² Must be an active employee of the University of Rochester Postdoc Scholar Benefit Program regularly working at least 30 hours per week.

Plan Name	Program Options	Active 1199 SEIU & SEIU Local 200 Union ¹	Active Union (IUOE, URPSOA, Teamsters Local Union No. 118) ¹	Active Full-Time or Part-Time Non-SEIU Union Faculty / Staff	LTD (Union/non-Union)	Active Residents/Fellows	Active Post-Docs	Retirees	
LTD Plan for Staff of University of Rochester who are Members of 1199 Upstate SEIU	N/A	Yes	No	No	N/A – In claim status	No	No	No	
Severance Pay for Staff of the University of Rochester	N/A	Yes	Yes	Yes for Staff only (Faculty not eligible)	No	No	No	No	
Employee Assistance Program for Faculty & Staff of the University of Rochester	N/A	Yes	Yes	Yes	Yes	Yes	Yes	Yes ³	
Health Care Plans for Faculty and Staff of the University of Rochester	YOUR PPO Plan	No	Yes ⁵	Yes ⁵	Yes with Medicare carve-out ⁴	Yes	No	Non-Medicare-eligible only	
	YOUR HSA-Eligible Plan	No	Yes ⁵	Yes ⁵	Yes with Medicare carve-out ⁴	Yes	No	Non-Medicare-eligible only	
	Gallagher Aetna Open Access Managed Choice POS	No	No	No	No	No	Yes	No	
	Gallagher Aetna Vision Preferred PPO	No	No	No	No	No	Yes	No	
	VSP Vision Care Plan	Yes	Yes	Yes	No	Yes	No	No	
	Condition Management Coaching	No	Yes if enrolled in medical and not in union plan	Yes if enrolled in medical	Yes if enrolled in medical and not in union plan	Yes if enrolled in medical	Yes if enrolled in medical	Yes if enrolled in medical	Non-Medicare-eligible enrolled in Medical only
	Behavioral Health Partners	No	No	Yes if enrolled in medical	Yes if enrolled in medical and not in union plan	Yes if enrolled in medical	No	Non-Medicare-eligible enrolled in Medical only	

³ Retirees are eligible for the EAP for only the first 18 months following termination of active employment.

⁴ SEIU members become eligible for coverage under the University Health Care Plan while they are receiving benefits under the University of Rochester Long Term Disability Plan (LTD). A form must be completed and submitted to the Office of Human Resources within 30 days of the LTD approval date to enroll in the coverage.

⁵ Time-as-reported (TAR), Travel-at-Home nurses, and retirees who return to active employment may also be eligible if they satisfy criteria in the University’s Look-Back Measurement Period Guidelines.

Plan Name	Program Options	Active 1199 SEIU & SEIU Local 200 Union ¹	Active Union (IUOE, URPSOA, Teamsters Local Union No. 118) ¹	Active Full-Time or Part-Time Non-SEIU Union Faculty / Staff	LTD (Union/non-Union)	Active Residents/Fellows	Active Post-Docs	Retirees
	Lifestyle Management	No	Yes if enrolled in medical and not in union plan	Yes if enrolled in medical	Yes if enrolled in medical and not in union plan	Yes if enrolled in medical	Yes if enrolled in medical	Non-Medicare-eligible enrolled in Medical only
	Flexible Spending Accounts	Yes	Yes	Yes	No	Yes	No	No
Dental Plans for Faculty and Staff of the University of Rochester	Traditional Dental Assistance Plan	No	Yes	Yes	Yes if non-SEIU union	Yes	No	Yes, if non-SEIU member
	Medallion Dental Plan	No	Yes	Yes	Yes if non-SEIU union	Yes	No	Yes, if non-SEIU member
	Gallagher Aetna Dental PPO	No	No	No	No	No	Yes	No
Long-Term Care Plan for Faculty and Staff of the University of Rochester	N/A	Yes	Yes subject to EOI	Yes subject to EOI	Yes subject to EOI	Yes subject to EOI	Yes subject to EOI	Yes subject to EOI
Long-Term Disability for Residents of the University of Rochester	N/A	No	No	No	N/A – In claim status	Yes	No	No
Legal Services Plan of the University of Rochester	N/A	Yes	Yes	Yes	No	Yes	No	No
University of Rochester Retiree Health Reimbursement Arrangement	N/A	No	No	No	No	No	No	Yes subject to full retirement and Medicare eligibility

Dependent Eligibility

If you are eligible for coverage for the plan benefits set forth in this exhibit (see the employee eligibility chart to determine your eligibility) and enroll in coverage, your dependents will be eligible as follows:

Plan Name	Program Options	Spouse ⁸	Domestic Partner ⁹	Children ^{6,10}	Domestic Partner Children ⁷	Retiree Spouse ⁸	Retiree Domestic Partner ⁹	Retiree Children ¹⁰
Employee Assistance Program for Faculty & Staff of the University of Rochester	N/A	Yes	Yes	No ¹¹	Yes	Yes, for the first 18 months following the employee's retirement	Yes, for the first 18 months following the employee's retirement	Yes, for the first 18 months following the employee's retirement
Health Care Plans for Faculty and Staff of the University of Rochester	YOUR PPO Plan	Yes	Yes	Yes	Yes	Yes (Non-Medicare eligible only)	Yes (Non-Medicare-eligible only)	Yes (Non-Medicare-eligible only)
	YOUR HSA-Eligible Plan	Yes	Yes	Yes	Yes	Yes (Non-Medicare eligible only)	Yes (Non-Medicare eligible only)	Yes (Non-Medicare-eligible only)

⁶ Children are eligible for medical, dental, vision, and legal services coverage through the end of the month in which they turn 26, regardless of access to other health care coverage through their own or a spouse's employment, marital status, or student status. Children who became handicapped prior to age 26 and are dependent on the employee for support are eligible for coverage beyond age 26.

⁷ Domestic partner children are eligible for medical, dental, vision, and legal services coverage through the end of the month in which they turn 26, regardless of access to other health care coverage through their own or a spouse's employment, marital status, or student status. Children who became handicapped prior to age 26 and are dependent on the employee for support are eligible for coverage beyond age 26.

⁸ Surviving spouses of retirees are eligible for medical coverage if, at the time of the participant's death, (1) the participant had met the age and service requirements to retire, (2) the participant was retired, and (3) the participant had five or more years of service but had not met the criteria to retire (in which case, the surviving spouse/domestic partner and eligible children remain eligible to continue coverage under a health care plan for one year following the participant's death. Following the one year of coverage, these individuals may be offered COBRA for up to 36 months). Surviving spouses are eligible for dental continuation coverage under COBRA following the retiree's death.

⁹ Surviving domestic partners of retirees are eligible for medical coverage if, at the time of the participant's death, (1) the participant had met the age and service requirements to retire, (2) the participant was retired, and (3) the participant had five or more years of service but had not met the criteria to retire (in which case, the surviving spouse/domestic partner and eligible children remain eligible to continue coverage under a health care plan for one year following the participant's death. Following the one year of coverage, these individuals may be offered COBRA for up to 36 months). Surviving spouses are eligible for dental continuation coverage under COBRA following the retiree's death.

¹⁰ Surviving children of retirees are eligible for medical coverage if, at the time of the participant's death, (1) the participant had met the age and service requirements to retire, (2) the participant was retired, and (3) the participant had five or more years of service but had not met the criteria to retire (in which case, the surviving spouse/domestic partner and eligible children remain eligible to continue coverage under a health care plan for one year following the participant's death. Following the one year of coverage, these individuals may be offered COBRA for up to 36 months). Children are eligible for medical, dental, and vision coverage through the end of the month in which they turn 26, regardless of access to other health care coverage through their own or a spouse's employment, marital status, or student status. Children who became handicapped prior to age 26 and are dependent on the employee for support are eligible for coverage beyond age 26.

¹¹ UR Medicine EAP does not see children. However, they do see parents/guardians regarding concerns that they may have about their child's emotional or behavioral health. In addition to providing education and support, EAP can provide information on appropriate community referrals for children. If, in consultation with parents, an EAP counselor determines that an older child (14 or above) is likely to benefit from the brief therapeutic services that EAP can provide, arrangements may be made to see the older child on a case by case basis.

Plan Name	Program Options	Spouse ⁸	Domestic Partner ⁹	Children ^{6,10}	Domestic Partner Children ⁷	Retiree Spouse ⁸	Retiree Domestic Partner ⁹	Retiree Children ¹⁰
	Gallagher Aetna Open Access Managed Choice POS	Yes	Yes	Yes	Yes	No	No	No
	VSP Vision Care Plan	Yes	Yes	Yes	Yes	No	No	No
	Gallagher Aetna Vision Preferred PPO	Yes	Yes	Yes	Yes	No	No	No
	Condition Management Coaching	Yes if enrolled in medical	Yes if enrolled in medical	No	No	Non-Medicare-eligible enrolled in Medical only	Non-Medicare-eligible enrolled in Medical only	No
	Behavioral Health Partners	Yes, if enrolled in medical	Yes if enrolled in medical	Yes if enrolled in medical and 18 or older	No	Non-Medicare-eligible enrolled in Medical only	Non-Medicare-eligible enrolled in Medical only	No
	Lifestyle Management	Yes, if enrolled in medical	Yes if enrolled in medical	No	No	Non-Medicare-eligible enrolled in Medical only	Non-Medicare-eligible enrolled in Medical only	No
	Flexible Spending Accounts	No	No	No	No	No	No	No
Dental Plans for Faculty and Staff of the University of Rochester	Traditional Dental Assistance Plan	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Medallion Dental Plan	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Gallagher Aetna Dental PPO	Yes	Yes	Yes	Yes	No	No	No
Legal Services Plan of the University of Rochester	N/A	Yes	Yes	Yes	Yes	Yes	Yes	No
University of Rochester Retiree Health Reimbursement Arrangement	N/A	Yes	Yes	Yes	Yes	No	Yes, if Medicare eligible	No

Eligibility Definitions:

Active Union (1199 SEIU SEIU Local 200, IUOE, URPSOA, Teamsters Local Union No. 118) – means an employee of the University whose employment and benefit eligibility is governed by the terms of a collective bargaining agreement entered into between the University and a bargaining unit.

Active Full-Time – means, for hourly staff (excluding those professional, administrative, and supervisory paid hourly): a regular¹² weekly work schedule of at least 35 hours; for all professional, administrative, and supervisory staff: a weekly work schedule of 40 hours or more; for faculty: a normal full teaching and research load as defined for the faculty by the college or school concerned. The University may use initial and look-back measurement periods to determine hours worked for purposes of offering medical coverage required by the Affordable Care Act, in accordance with IRS regulations and other applicable guidance (including the University’s Look-Back Measurement Period Guidelines).

Active Part-Time – means a regular¹¹ weekly or monthly schedule which is less than that required for full-time status but not less than 17.5 hours per week in the case of hourly and professional, administrative, and supervisory staff. For faculty it indicates that the individual carries at least half the normal (full) teaching and research load as defined for faculty by the college or school concerned. The University may use initial and look-back measurement periods to determine hours worked for purposes of offering medical coverage required by the Affordable Care Act, in accordance with IRS regulations and other applicable guidance (including the University’s Look-Back Measurement Period Guidelines).

LTD – means an eligible faculty or staff employee who (1) is receiving long term disability benefits from the University, (2) is Medicare-eligible, and (3) has enrolled in Medicare Parts A and B as of his/her Medicare-eligibility effective date. For purposes of University medical benefits, Medicare will be the primary payer.

Active Residents/Fellows – means an individual who is classified as a full time resident or fellow through the University, holds a degree of Doctor of Medicine and is a member or eligible for membership of the American Medical Association.

Active Post-Docs – means an individual with a Postdoctoral Appointment involving substantially full-time research or scholarship. It is a transitional position and is viewed as preparatory for an academic and/or research career. The appointee is not part of a clinical training program. The appointee was recently awarded the PhD or equivalent doctorate, works under the supervision of a faculty member and has the freedom and is expected to publish the results of his/her research or scholarship during the period of the appointment.

Children—means an employee’s biological or legally adopted children, in addition to stepchildren and children who are placed with the employee by an authorized placement agency or by judgement, decree, or other order of any court of competent jurisdiction.

Domestic Partner—means the same or opposite gender partner of an employee, who, together with the employee, satisfies all of the following criteria:

- Have an exclusive mutual commitment, similar to that of marriage;
- Are each other’s sole domestic partner and intend to remain so indefinitely;
- Are not legally married to each other or to anyone else in a marriage recognized by state or federal law;

¹² “Regular” means a period of appointment in hourly and professional, administrative, and supervisory positions that is expected to exceed four months, unless otherwise defined in collective bargaining agreements; period of appointment for faculty-instructional staff that is at least one year (or one academic year) or, if shorter, is expected to be renewed. Appointments primarily for furthering education (for example, graduate assistant) are not considered “regular” appointments.

- Are not related by blood to a degree of closeness which would prohibit legal marriage in the state in which the partners legally reside;
- Are at least 18 years of age and are legally competent to contract;
- Are currently residing together and have resided together in a common household for at least six consecutive months and intend to reside together indefinitely;
- At least six months have elapsed since the Total Rewards Office has received a Statement of Termination of Domestic Partnership from either partner; and
- Share joint responsibility for the partners' common welfare and financial obligations demonstrated by:
(a) the existence of a domestic partner agreement (a qualifying domestic partnership agreement is a legally binding agreement between two individuals creating personal and financial interdependence, i.e., joint and several liability for each other's debts and expenses, responsibility for mutual care, etc.); and
(b) at least two other items showing joint responsibility, such as joint bank accounts, joint deed, mortgage agreement or lease, joint credit account or other liability, joint ownership of a motor vehicle, designation of domestic partner as primary beneficiary for life insurance or retirement contract(s), designation of domestic partner as primary beneficiary of will, durable property or health care power of attorney, co-parenting agreement, or an adoption agreement.

Retiree—means the University Retired faculty and staff members who satisfy the following:

- For Regular Full-Time and Part-Time faculty and staff Hired or Rehired prior to 1/1/96 who: (1) Retire after age 55 and before 2024, and (2) who have completed 10 Years of Service at their Retirement. (Subject to such rules and requirements as are established by the Plan Administrator, the 10 Years of Service requirement may be met by cumulative employment at the University or another higher education institution).
- For Regular Full-Time and Part-Time faculty and staff Hired or Rehired on or after 1/1/96 who: (1) Retire after age 60 and before 2024, and (2) have completed 10 Years of Service at their Retirement. (Subject to such rules and requirements as are established by the Plan Administrator, the 10 Years of Service requirement may be met by cumulative employment at the University or another higher education institution as long as there is Continuous Employment at the University for the immediate five years prior to Retirement).
- For Regular Full-Time and Part-Time faculty and staff Hired or Rehired prior to 1/1/96 who: (1) Retire after age 55 and after 2023, and (2) who have completed 15 Years of Service at their Retirement. (Subject to such rules and requirements as are established by the Plan Administrator, the 15 Years of Service requirement may be met by cumulative employment at the University or another higher education institution).
- For Regular Full-Time and Part-Time faculty and staff Hired or Rehired on or after 1/1/96 who: (1) Retire after age 60 and after 2023, and (2) who have completed 15 Years of Service at their Retirement. (Subject to such rules and requirements as are established by the Plan Administrator, the 15 Years of Service requirement may be met by cumulative employment at the University or another higher education institution).

Once Retired, Post-Retirement Benefits continue to be based on status, age, and years of service at the time of initial Retirement, even if the Retiree returns to work. There is no adjustment to the Retiree Level, years of service, or age calculation to determine the level of Post-Retirement benefits based upon Post-Retirement Rehire and employment. However, in the event a Retiree returns to work and becomes eligible for Health Care Plan coverage, Dental Plan coverage, and/or University-paid Basic Term Life insurance coverage because the

Retiree has satisfied the eligibility criteria for active employees to participate, the Retiree will be limited to the active employee options and will become ineligible for the post-retirement benefit options.

Retirement or Retire—mean the ending of an appointment (whether voluntary or involuntary) after satisfying the requirements to be treated as a Retiree.

TAR (Time-As-Reported)—means an appointment with (1) no regular schedule, or (2) in which the individual is expected to work fewer than 17.5 hours per week in the case of hourly and professional, administrative, and supervisory staff, unless otherwise defined in collective bargaining agreements. For faculty it indicates that the individual carries less than half the normal (full) teaching and research load as defined for faculty by the college or school concerned.

Spouse—means the employee's current spouse, if the marriage was valid in the state or country where it was performed.

Years of Service-means years of service at work in a position eligible for the full range of University Benefit Plans as calculated from the credited service records maintained by the Plan Administrator.

EXHIBIT C

Eligibility Claims Procedure

The following procedures shall apply if you (or an authorized representative acting on your behalf) are inquiring about your eligibility to participate in a Program. These rules do not apply if you are claiming the right to receive benefits under a Program rather than just inquiring about your eligibility. If you are filing a claim for benefits, please refer to the claims procedures that apply to the particular Program under which you are claiming benefits. Any claim for eligibility shall be submitted to the Plan Administrator in writing. The Plan Administrator will generally notify the claimant of its decision within 90 days after it receives the claim. However, if the Plan Administrator determines that special circumstances require an extension of time to decide the claim, it may obtain an additional 90 days to decide the claim. Before obtaining this extension, the Plan Administrator will notify the claimant, in writing and before the end of the initial 90-day period, of the special circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision.

If the claimant's claim is denied in whole or in part, the Plan Administrator will provide the claimant, within the time period described in this exhibit, with a written or electronic notice which explains the reason or reasons for the decision, includes specific references to plan provisions upon which the decision is based, provides a description of any additional material or information which might be helpful to decide the claim (including an explanation of why that information may be necessary), and describes the appeals procedures and applicable filing deadlines.

If a claimant disagrees with the decision reached by the Plan Administrator, the claimant may submit a written appeal requesting a review of the decision. The claimant's written appeal must be submitted within 60 days of receiving the initial adverse decision. The claimant's written appeal should clearly state the reason or reasons why the claimant disagrees with the Plan Administrator's decision. The claimant may submit written comments, documents, records and other information relating to the claim even if such information was not submitted in connection with the initial claim for benefits. Additionally, the claimant, upon request and free of charge, may have reasonable access and copies of all Plan documents, records and other information relevant to the claim.

The Plan Administrator will generally decide a claimant's appeal within 60 days. If special circumstances require an extension of time for reviewing the claim, the claimant will be notified in writing. The notice will be provided prior to the commencement of the extension, describe the special circumstances requiring the extension and set forth the date the Plan Administrator will decide the appeal, which date will be no later than 60 days from the end of the first 60-day period.

Once the Plan Administrator has made a decision, the claimant shall receive written or electronic notification of the decision within five (5) days. In the case of an adverse decision, the notice will explain the reason or reasons for the decision, include specific references to Plan provisions upon which the decision is based, and indicate that the claimant is entitled to, upon request and free of charge, reasonable access to and copies of documents, records, and other information relevant to the claim.

EXHIBIT D

Benefit Claims Procedure

Any participant or dependent or an authorized representative acting on behalf of a participant or dependent, may assert a claim for benefits. Throughout this section, any of these individuals are referred to generically as the “Claimant.”

All claims for benefits under a Program shall be submitted in accordance with the terms of that Program and shall be subject to the claims review procedure established for that Program. However, if the particular issue on which a claim is based does not relate to any Program, or if the Program lacks a claims procedure that satisfies any then-applicable ERISA claims procedure requirements, the relevant following claims procedures (health, disability, or other) shall apply or supplement the defective procedures to bring them into compliance. Where a Program’s materials with a defective claims procedure specify that claims can be filed or must be responded to in a time period more generous than the procedures in this document, then these procedures shall also be read to require the more generous time period for submission or response.

The “Claims Reviewer” is the individual or entity assigned to review claims or appeals for a Program. Where a Program’s materials specify that claims be sent to an insurer or third party administrator, then the insurer or third party administrator shall be the Claims Reviewer for purposes of the procedures that follow. Where a Program’s materials do not contain any claims procedure, then the following procedures shall apply, with the Plan Administrator (or its delegate) acting as the Claims Reviewer for all internal claims and appeals.

Health Plan Claims Procedures

This procedure applies only to claims submitted for medical care benefits under a Program. In addition, it applies to any rescission (as defined under the Patient Protection and Affordable Care Act (PPACA) and guidance thereunder) of coverage that is not attributable to a failure to timely pay required premiums or contributions toward the cost of coverage. You will be provided with 30 days’ advance written notice of any rescission.

If you need assistance with your claim, appeal of a denied claim, or the external review process, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

All claims and appeals under the Plan will be adjudicated in such a manner as to maintain the independence and impartiality of all those involved in making a benefit decision. Decisions regarding the hiring, compensation, termination, promotion, incentives or other similar matters regarding any individual or organization making decisions in the claims and appeals process (such as a claims adjudicator, medical expert, or Independent Review Organization) will not be made based upon the likelihood that the individual or organization will support the denial of benefits.

Certain aspects of the claims procedures apply only to Plans that are not grandfathered medical plans under 26 CFR § 54.9815-1251T and that are subject to the expanded claims procedure requirements under the Patient Protection and Affordable Care Act (PPACA). Those sections are indicated throughout the procedures that follow. In cases where the Department of Labor has indicated that there is a delayed enforcement deadline for a particular PPACA requirement described in this section, the Claims Reviewer may delay implementation of the particular delayed provision until the enforcement deadline.

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the Plan will continue to provide coverage pending the outcome of an appeal, to the extent required by PPACA, in accordance with the requirements of 29 CFR 2560.503-1(f)(2)(ii), which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

I. Internal Review

A. Definitions.

The following terms are defined for purposes of this subsection:

1. *Post-Service Claim* means any claim for a benefit which is not a Pre-Service Claim as defined in this exhibit.

2. *Pre-Service Claim* means any claim for benefits whereby the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining health care.

3. *Urgent Care Claim* means a claim for health care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- a. Could seriously jeopardize the Claimant's life or health or the ability of the Claimant to regain maximum function, or
- b. In the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The determination of whether a claim involves Urgent Care will be made by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that a claim shall automatically be treated as an Urgent Care claim if a physician with knowledge of the Claimant's medical condition determines that the claim involves Urgent Care.

4. *Plan* means, for purposes of this claims procedure, any Program listed in Exhibit A that provides benefits for health care or treatment.

5. *Claims Reviewer* means the person or entity responsible for the relevant claims determination under the Plan.

B. Determination of Benefits

The amount of time that the Claims Reviewer has to respond to a claim for benefits will depend upon the type of claim for benefits being made, as provided in this exhibit.

1. *Post-Service Claims.* The Claims Reviewer will notify the Claimant of the benefits determination within a reasonable period of time after receiving the claim, but not later than 30 days after the claim is received. This period may be extended by the Plan for up to 15 days, provided that the Claims Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and provides the Claimant with written notification prior to the expiration of the initial 30-day period explaining the reason for the additional extension and

when the Plan expects to decide the claim. If the initial 30-day period of time is extended due to the Claimant's failure to submit information necessary to decide a claim, the written notification will set forth the specific information required and the Claimant will have at least 45 days to provide the requested information. In that case, the Plan's timeframe for making a benefit determination is tolled from the date the Claims Reviewer sends the Claimant an extension notification until the date the Claimant responds to the request for additional information or the Claimant's time to respond expires. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information was received by the Plan.

2. Pre-Service Claims. The Claims Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not more than 15 days after receiving the claim. This period may be extended by the Plan for up to 15 days, provided that the Claims Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and provides the Claimant with written notification prior to the expiration of the initial 15-day period explaining the reason for the additional extension and when the Plan expects to decide the claim. If the initial 15-day period of time is extended due to the Claimant's failure to submit information necessary to decide a claim, the written notification will set forth the specific information required and the Claimant will have at least 45 days to provide the requested information. In that case, the Plan's timeframe for making benefits determination is tolled from the date the Claims Reviewer sends the Claimant an extension notification until the date the Claimant responds to the request for additional information or the Claimant's time to respond expires. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information is received by the Plan.

In the event the Claimant fails to follow proper Plan procedures in submitting a claim, the Claimant will be notified within five days after the Plan initially receives the claim so that the Claimant can make proper adjustments.

3. Urgent Care Claims. The Claims Reviewer will notify the Claimant of its benefit determination (whether adverse or not) as soon as reasonably possible, taking into consideration the medical circumstances involved. The Claims Reviewer will always respond to an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no more than 72 hours after receipt of the claim (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the Plan will defer to the attending provider with respect to the decision as to whether a claim is an Urgent Care Claim), unless the Claimant fails to submit information necessary to decide a claim. In this situation, the Claimant will be informed within 24 hours after submitting the claim the specific information necessary to complete the claim. Notification may be oral, unless the Claimant requests written notification. The Claimant will be given at least 48 hours to provide the requested information. The Claims Reviewer will notify the Claimant of the benefit determination no later than 48 hours after the earlier of the Plan's receipt of the requested information or the end of the period the Claimant was given to supply the additional information.

In the event the Claimant fails to follow proper Plan procedures in submitting a claim, the Claimant will be notified within 24 hours after the Plan initially receives the claim so that the Claimant can make proper adjustments.

4. Concurrent Care Decisions. In certain situations, the Plan may approve an ongoing course of treatment. For example, treatment provided over a period of time or approval of a certain number of treatments. If the Plan reduces or terminates the course of treatment before its completion, except in the case where the Plan is amended or terminated in its entirety, this shall constitute an adverse benefit determination. The Claims Reviewer will notify the Claimant of this adverse benefit determination within sufficient time to allow the Claimant to appeal the decision and obtain a determination on review before the benefit is reduced or terminated.

If the Claimant requests to extend the course of treatment and the claim involves an Urgent Care situation, the Claims Reviewer will notify the Claimant of the claim determination (whether adverse or not) as soon as possible, but in no case more than 24 hours after the Claimant requests an extension, provided that the Claimant submits such claim at least 24 hours prior to the expiration of the initial treatment period.

C. Notification of Adverse Claim Determination

If the Claimant's claim for benefits is denied, in whole or in part, the Claimant or the Claimant's authorized representative will receive a written notice of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

1. the specific reason(s) for the denial;
2. sufficient information to identify the claim involved, including the date of service, the health care provider, and if applicable, the claim amount (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);
3. references to the specific Plan provisions on which the benefit determination was based;
4. a description of any additional material or information necessary for the Claimant to perfect a claim and an explanation of why such information is necessary;
5. a statement that Claimant is entitled to receive, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);
6. a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;
7. a description of the Plan's internal appeals procedures, any applicable the external review process, information regarding how to file an appeal, and applicable time limits, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review;

8. if the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to the Claimant free of charge upon request;
9. if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the particular medical circumstances, or a statement that this will be provided free of charge upon request;
10. identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination;
11. the denial code and its corresponding meaning (if applicable), as well as a description of the Plan's standard, if any, that was used in denying the claim (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);
12. the contact information for the Employee Benefits Security Administration any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA); and
13. in the case of an adverse determination involving urgent care, a description of the expedited review process available to such claims.

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the notice will also be written in a culturally and linguistically appropriate manner as defined by applicable regulations.

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, upon request as soon as practicable. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review.

In order to expedite the process in a situation involving an Urgent Care Claim, the Claimant may initially be notified of an adverse claim determination orally, but a written notification providing the information set forth in this exhibit shall follow within three days.

D. Appeal of Adverse Claim Determination

If a claim for benefits is denied, the Claimant may appeal the denied claim in writing to the Claims Reviewer within 180 days after receiving the written notice of denial. The Claimant may submit with this appeal any written comments, documents, records and any other information relating to the claim. Upon request, the Claimant will also have access to, and the right to obtain copies of, all Plan documents, records and information relevant to the claim free of charge. In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the Claimant is entitled to

review the Plan's claim file and to present evidence and testimony in support of his or her claim.

If the situation involves an Urgent Care Claim, the Claimant can request an expedited review process whereby the Claimant may submit the appeal orally or in writing, and all necessary information, including the Plan's benefit determination on review, shall be relayed to the Claimant by telephone, fax, or other similarly expeditious method.

A full review of the information in the claim file and any new information submitted to support the appeal, including all comments, documents, records, and other information will be conducted. The claim determination will be made by the Claims Reviewer of the Plan. The Claims Reviewer will not have been involved in the initial benefit determination nor is the subordinate of the person making the initial determination. This review will not afford any deference to the initial claim determination.

If the initial adverse decision was based in whole or in part on a medical judgment, the Claims Reviewer will consult a healthcare professional who has appropriate training and experience in the relevant field of medicine and who was not consulted in the initial adverse benefit determination and is not a subordinate of the healthcare professional who was consulted in the initial adverse benefit determination. If a healthcare professional is contacted in connection with the appeal, the Claimant will have the right to learn the identity of such individual.

E. Interim Notification of New Evidence or Rationale during pendency of Internal Appeal

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, if during the pendency of the claim or appeal the Plan obtains any new or additional evidence that is considered, relied upon, or generated by or at the direction of the Plan in connection with the claim, the Plan will provide the Claimant with the new or additional evidence at no cost as soon as possible and sufficiently in advance of the date when the Plan must provide notice of its decision regarding the claim on appeal to give the Claimant a reasonable opportunity to respond prior to that date.

Additionally, before the Plan denies such a claim on appeal in whole or part based on a new or additional rationale, the Plan will provide the Claimant with the new or additional rationale at no cost as soon as possible and sufficiently in advance of the date when the Claims Reviewer must provide notice of its decision regarding the claim on appeal to give the Claimant a reasonable opportunity to respond prior to that date.

F. Notification of Final Internal Decision on Appeal

After an appeal is filed, the Claims Reviewer will respond to the claim within a certain period of time. The amount of time that the Claims Reviewer has to respond is based on the underlying claim for benefits as set forth in this exhibit:

Post-Service Claims: Within a reasonable period, but no more than 60 days after receiving Claimant's appeal request

Pre-Service Claims: Within a reasonable time appropriate to medical circumstances, but no more than 30 days after receiving Claimant's appeal request

Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but no more than 72 hours after receiving

Claimant's appeal request (in the case of non-grandfathered health plans

subject to the expanded claims procedure

requirements under PPACA, the Plan will defer to the attending provider with respect to the decision as to whether a claim is an Urgent Care Claim)

If the claim on appeal is denied in whole or in part, the Claimant will receive a written notification of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

1. the specific reason(s) for the denial;
2. sufficient information to identify the claim involved, including the date of service, the health care provider, and if applicable, the claim amount (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);
3. references to the specific Plan provisions on which the benefit determination was based;
4. a statement that Claimant is entitled to receive, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);
5. a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;
6. a description of any voluntary review procedures, internal appeals and the external review process, including information on how to initiate an appeal and applicable time limits;
7. if the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to the Claimant free of charge upon request;
8. if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the particular medical circumstances, or a statement that this will be provided free of charge upon request;
9. identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination;
10. the denial code and its corresponding meaning (if applicable), as well as a description of the Plan's standard, if any, that was used in denying the claim (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);

11. a discussion of the decision to deny the claim (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);
12. disclosure of the availability of, and the contact information for, the Employee Benefits Security Administration any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793 (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA); and
13. a statement describing voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and the right to bring a civil legal action under ERISA.

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the notice will also be written in a culturally and linguistically appropriate manner as defined by applicable regulations.

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, upon request as soon as practicable. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review.

II. External Review

The following review procedures apply to non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA. Specifically, they apply to such plans that are self-insured. Fully-insured group health Plans subject to external review requirements are generally subject to applicable state external review procedures, as outlined in each Plan. However, in the event those state external review procedures do not comply with PPACA requirements by the enforcement deadline imposed by the Departments of Labor and Health and Human Services, then such fully-insured Plans will be governed by these procedures to the extent necessary to comply with PPACA.

These procedures are intended to comply with the interim safe harbor contained in U.S. Department of Labor Technical Release 2010-01, as modified by Department of Labor Technical Release 2011-01, Department of Labor Technical Release 2011-02, and 76 Fed. Reg. 37208-37234 (June 24, 2011). At such time that guidance is revised or replaced by the Department, the new guidance shall be incorporated by reference herein and these procedures will be superseded by such new guidance to the extent necessary to comply with PPACA.

A. Standard External Review

This Section II.A. describes the procedures for standard external review. Standard external review is external review that is not considered expedited (as described in Section II.B. of this exhibit).

1. Requests for External Review. A Claimant may file a request for external review within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For

example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. Except for requests for external review initiated before September 20, 2011, external review is only available for:

- a. A rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time; and
- b. An adverse benefit determination (including a final adverse benefit determination) that involves medical judgment, as determined by the external reviewer. An adverse benefit determination that involves medical judgment includes, but is not limited to, an adverse benefit determination based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or the Plan's determination that a treatment is experimental or investigational. Additional examples of situations where a claim is considered to involve medical judgment include adverse benefit determinations based on:
 - i. The appropriate health care setting for providing medical care to an individual (such as outpatient versus inpatient care or home care versus rehabilitation facility);
 - ii. Whether treatment by a specialist is medically necessary or appropriate (pursuant to the Plan's standard for medical necessity or appropriateness);
 - iii. Whether treatment involved "emergency care" or "urgent care", affecting coverage or the level of coinsurance;
 - iv. A determination that a medical condition is a preexisting condition;
 - v. The Plan's general exclusion of an item or service, if the Plan covers the item or service in certain circumstances based on a medical condition;
 - vi. Whether a participant or dependent is entitled to a reasonable alternative standard for a reward under the Plan's wellness program, if any;
 - vii. The frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified, in the recommendation or guideline of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration (as described in PHS Act section 2713 and its implementing regulations); and
 - viii. Whether the Plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques.

2. Preliminary Review. Within five (5) business days after the date of receipt of the external review request, the Claims Reviewer will review the request to determine whether:

- a. The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- b. The adverse benefit determination or the final adverse benefit determination does not relate to the Claimant's failure to meet the requirements for eligibility to participate under the terms of the Plan (eligibility claims are not subject to external review);
- c. The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the final internal appeals process; and
- d. The Claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Claims Reviewer will issue a written notification to the Claimant. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and the toll-free (if available) contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. The Plan will allow a Claimant to perfect the request for external review within the later of: (a) the four-month filing period, or (b) the 48-hour period after the receipt of notification.

3. Referral to Independent Review Organization. The Claims Reviewer will assign an independent review organization (IRO) accredited by a nationally-recognized accrediting organization to conduct the external review. The Plan will rotate claim assignments among the IROs or incorporate other independent, unbiased methods for selection of IROs, such as random selection. The contract between the Plan and an IRO will provide the following:

- a. The IRO will use legal experts where appropriate to make coverage determinations under the Plan.
- b. The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten (10) business days after the date of receipt of the notice that the IRO must consider when conducting external review. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days.
- c. Within five (5) business days after the date of assignment of the IRO, the Plan will provide the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review. If the Plan does not timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse benefit

determination or final internal adverse benefit determination. Within one business day after making such a decision, the IRO must notify the Claimant and the Plan.

- d. Upon receipt of any information submitted by the Claimant, the IRO must within one (1) business day forward the information to the Plan. The Claims Reviewer may, but is not required to, reconsider its adverse benefit determination or final internal adverse benefit determination. Reconsideration by the Plan will not delay the external review. If the Claims Reviewer decides to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment, the Claims Reviewer will provide written notice of its decision to the Claimant and the IRO within one (1) business day after making its decision. The IRO will terminate the external review upon receiving this notice from the Claims Reviewer.
- e. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
 - i. The Claimant's medical records;
 - ii. The attending health care professional's recommendation;
 - iii. Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, Claimant, or the Claimant's treating provider;
 - iv. The terms of the Plan to ensure that the IRO's decision is not contrary to the Plan's terms, unless the terms are inconsistent with applicable law;
 - v. Appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - vi. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the Plan's terms or with applicable law; and
 - vii. The opinion of the IRO's clinical reviewer or reviewers after considering the available information or documents to the extent the clinical reviewer or reviewers consider appropriate.
- f. The IRO will provide written notice to the Claimant and the Plan of the final external review decision within 45 days after the IRO receives the request for the external review. The notice will contain:
 - i. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, and if applicable, the claim amount, the diagnosis code and its corresponding meaning, the

treatment code and its corresponding meaning, and the reason for the previous denial);

- ii. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- iii. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision;
- iv. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- v. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or the Claimant;
- vi. A statement that judicial review may be available to the Claimant; and
- vii. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The final external review decision is binding on the Plan and the Claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denied the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan must provide any benefits, including by making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

B. Expedited External Review

1. Request for Expedited External Review. When external review is otherwise available, the Plan will allow a Claimant to make a request for an expedited external review at the time the Claimant receives:

- a. An adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal, or
- b. A final internal adverse benefit determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final

internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant receive emergency services, but has not been discharged from a facility.

2. Preliminary Review. Immediately upon receipt of the request for expedited external review, the Claims Reviewer will review the request to determine whether the request meets the reviewability requirements described in Section II.A.2. in this exhibit for Standard External Review. The Plan must immediately send a notice that meets the requirements set forth in Section II.A.2. for Standard External Review to the Claimant of its eligibility determination.

3. Referral to Independent Review Organization. Upon determination that a request is eligible for expedited external review following preliminary review described in Section II.B.2. in this exhibit, the Claims Reviewer will assign an independent review organization (IRO) in accordance with the requirements described in Section II.A.3. in this exhibit for Standard External Review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefits determination to the assigned IRO electronically or by telephone or fax or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described in this exhibit under the procedures for Standard External Review. In reaching a decision, the IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of Final External Review Decision. The IRO will provide written notice to the Claimant and the Plan of the final external review decision, in accordance with the requirements of Section II.A.3.f. in this exhibit for Standard External Review, except that the notice will be provided as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, then within 48 hours after the date of providing that notice, the IRO must provide written confirmation of that decision to the Claimant and the Plan.

5. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The final external review decision is binding on the Plan and the Claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denied the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan must provide any benefits, including by making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

C. IRO Recordkeeping Requirements

After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six (6) years. An IRO must make such records available for examination by the Claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Disability Plan Claims Procedures

If the Claimant submits a claim for disability benefits provided under an insurance policy or any other contract for disability benefits administered by an outside provider, the claims and appeals procedures set forth in the insurer's or other third-party administrator's policy or contract must be followed. If the disability Program is administered by the Employer or if an outside provider has failed to establish a claims and appeals procedure, the following procedures must be followed:

A. Determination of Benefits

For the purposes of this disability benefit claims procedure, the term Claims Reviewer means the person or entity responsible for the relevant determination under a disability Program and the term Plan means any Program that provides benefits in the event of a disability. The Claims Reviewer will notify the Claimant of the claim determination within 45 days of the receipt of the claim. This period may be extended by 30 days if an extension is necessary to process the claim due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and when the Plan expects to decide the claim, will be furnished to the Claimant within the initial 45-day period. This period may be extended for an additional 30 days beyond the original extension. A written notice of the additional extension, the reason for the additional extension and when the Plan expects to decide the claim, will be furnished within the first 30-day extension period if an additional extension of time is needed. All notices of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and that the Claimant will have at least 45 days to provide the requested information. If a period of time is extended due to the Claimant's failure to submit information necessary to decide the claim, the period for making the benefit determination by the Claims Reviewer will be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information or the Claimant's time to respond expires. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information received by the Plan.

B. Notification of Adverse Claim Determination

If the claim for benefits is denied, in whole or in part, the Claimant will receive a written notice of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

1. the specific reason(s) for the denial;
2. references to the specific Plan provisions on which the benefit determination was based;

3. a description of any additional material or information necessary for the Claimant to perfect a claim and an explanation of why such information is necessary;
4. a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;
5. a description of the Plan's appeals procedures and applicable time limits, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review;
6. a discussion of the decision, including an explanation of the Plan's basis for disagreeing with or not following:
 - i. the views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;
 - ii. the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
 - iii. the Claimant's disability determination by the Social Security Administration that the Claimant presented to the Plan;
7. either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the claim or, alternatively, a statement that these sorts of rules, guidelines, protocols, standards or criteria of the Plan do not exist; and
8. if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the particular medical circumstances; or a statement that this will be provided free of charge upon request.

C. Appeal of Adverse Determination

If a claim for benefits is denied, the Claimant may appeal the denied claim in writing to the Claims Reviewer within 180 days of the receipt of the written notice of denial. The Claimant may submit with the appeal any written comments, documents, records and any other information relating to the claim. Upon request, the Claimant will also have access to, and the right to obtain copies of, all Plan documents, records and information relevant the claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted. The claim determination will be made by the Claims Reviewer of the Plan. The Claims Reviewer will not have been involved in the initial benefit determination nor will the Claims Reviewer be the subordinate of any individual involved in the initial claim for benefits. This review will not afford any deference to the initial claim determination.

If the initial adverse decision was based in whole or in part on a medical judgment, the Claims Reviewer will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment, was not consulted in the initial adverse benefit determination and is not a subordinate of the healthcare professional who was consulted in the initial adverse benefit determination.

D. Notification of Decision on Appeal

The Claims Reviewer will make a determination on the appeal within 45 days of the receipt of the appeal request. This period may be extended for an additional 45 days if the Claims Reviewer determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the Claims Reviewer expects to render a decision will be furnished to the Claimant within the initial 45-day period. However, if the period of time is extended due to the Claimant's failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which the Claimant responds to the request for additional information.

In connection with the appeal, a Claimant may submit written comments, documents, records, and other information relating to the claim. In addition, the Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. The review of the appeal will take into account all comments, documents, records, and other information that the Claimant submits, whether or not the Claimant first raised the issues or first submitted that information when the claim was originally considered.

The claim will be reviewed independently of the original claim and will be conducted by a named fiduciary of the Plan other than the Claims Reviewer.

In deciding an appeal of a claim denial that is 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 appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will not be the same person who was consulted in connection with the original claim or any of his or her employees.

The Claims Reviewer will provide the Claimant with the name(s) of the health care professional(s) who was/were consulted in connection with the original claim, even if the claim denial was not based on his/her/their advice.

Before the Plan can deny the Claimant's appeal, the Claims Reviewer will provide the Claimant, free of charge, with:

1. Any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim; and
2. Any new or additional rationale on which the denial of the appeal will be based.

This evidence and rationale will be provided as soon as possible and sufficiently in advance of the expiration of the 45-day period discussed in this exhibit in order to give the Claimant a reasonable opportunity to respond prior to that date.

If the claim on appeal is denied in whole or in part, the Claimant will receive a written notification of the denial. The notice will be written in a culturally and linguistically appropriate manner calculated to be understood by the Claimant and will include:

1. the specific reason(s) for the adverse determination;
2. references to the specific Plan provisions on which the determination was based;
3. a statement that the Claimant is entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to the Claimant's benefit claim upon request;
4. a description of any voluntary review procedures and applicable time limits, the Claimant's right to obtain the information about those procedures, a statement of the Claimant's right to bring an action under Section 502(a) of ERISA, and a description of any applicable contractual limitations period that applies to the Claimant's right to bring the action, including the calendar date on which the contractual limitations period expires for the claim;
5. a discussion of the decision, including an explanation of the Plan's basis for disagreeing with or not following:
 - a. the views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;
 - b. the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
 - c. the Claimant's disability determination by the Social Security Administration that the Claimant presented to the Plan;
6. either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the claim on appeal or, alternatively, a statement that those sorts of rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
7. if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the particular medical circumstances, or a statement that an explanation will be provided free of charge.

Other Claims for Benefits

The Claims Reviewer shall maintain a procedure under which any participant or dependent (or an authorized representative acting on behalf of a participant or dependent) may assert a claim for benefits not covered by the claims procedures for health plans set

forth in this exhibit. Any such claim shall be submitted to the Claims Reviewer in writing. The Claims Reviewer will generally notify the Claimant of its decision within 90 days after it receives the claim. However, if the Claims Reviewer determines that special circumstances require an extension of time to decide the claim, it may obtain an additional 90 days to decide the claim. Before obtaining this extension, the Claims Reviewer will notify the Claimant in writing, and before the end of the initial 90-day period, of the special circumstances requiring the extension and the date by which the Claims Reviewer expects to render a decision.

If the claim is denied in whole or in part, the Claims Reviewer will provide the Claimant with a written notice which explains the reason or reasons for the decision, includes specific references to Plan provisions upon which the decision is based, provides a description of any additional material or information which might be helpful to decide the claim (including an explanation of why that information may be necessary), and describes the appeals procedures and applicable filing deadlines, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review. It will also include a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits. If the Claimant disagrees with the decision reached by the Claims Reviewer, the Claimant may submit a written appeal requesting a review of the decision. The written appeal must be submitted within 60 days of receiving the initial adverse decision. The appeal should clearly state the reason or reasons why the Claimant disagrees with the Claims Reviewer's decision. The Claimant may submit written comments, documents, records and other information relating to the claim even if such information was not submitted in connection with the initial claim for benefits. Additionally, upon request and free of charge, the Claimant may have reasonable access and copies of all Plan documents, records and other information relevant to the claim. The Claims Reviewer will generally notify the Claimant of its decision on appeal within 60 days after the appeal is received, unless special circumstances require an extension of time for processing, in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision will be in writing and will include specific reasons for the decision, with specific references to the pertinent Plan provisions on which the decision is based; and a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. It will also describe any voluntary appeal procedures and applicable time limits, a statement describing the voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and the right to bring a civil legal action under ERISA.

Statute of Limitations and Exhaustion of Administrative Remedies

All claims for benefits must be submitted by the claims filing deadline specified under the rules for a particular Program. If the Program does not specify a filing deadline, then claims must be submitted within one year from the date the services relating to the claim were performed or the event that gave rise to the benefit occurred. This requirement may be waived by the Plan if, through no fault of the participant or dependent, the claim is filed after the deadline but is filed as soon as practicable and within a reasonable time period, given the particular circumstances. Except in the case of legal incapacitation, late claims will not be accepted if they are filed more than two years from the date the services relating to the claim were performed or the event that gave rise to the benefit occurred.

The Claimant may not commence a judicial proceeding against any person, including the Plan, a Plan fiduciary, the Plan Administrator, the Claims Reviewer, the Plan Sponsor, or any other person, with respect to a claim for benefits without first exhausting the claims procedures set forth in this exhibit. A Claimant who has exhausted these procedures and is dissatisfied with the decision on appeal of a denied claim may bring an action under Section 502 of ERISA in an appropriate court to review the Claims Reviewer's or Plan Administrator's decision on appeal, but only if such action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the decision on appeal.

A. Failure to Follow the Claims Procedure for Health Plan Claims or Rescissions of Health Plan Coverage

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, then notwithstanding the previous paragraph, if the Plan fails to adhere to all of the requirements of the procedures set forth in this exhibit for health Plan claims or rescissions of health Plan coverage, then to the extent mandated by PPACA, the Claimant may initiate an external review or bring an action in an appropriate court under state law or section 502(a) of ERISA, but only if the action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the Claims Reviewer's decision on appeal. However, the Claimant cannot initiate an external review or bring an action in an appropriate court under state law or section 502(a) of ERISA without first exhausting the claims procedures set forth in this exhibit if the violation by the Plan was:

1. *De minimis*;
2. Not likely to cause, prejudice or harm to the Claimant;
3. Attributable to good cause or matters beyond the Plan's control;
4. In the context of an ongoing good-faith exchange of information; and
5. Not reflective of a pattern or practice of non-compliance by the Plan.

Within 10 days of the Plan's receipt of a written request by the Claimant, a Claimant is entitled to an explanation of the Plan's basis for asserting that it meets the in this exhibit exception that includes a specific description of its bases, if any, for asserting the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the requirements for the exception, then the Plan will provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim within a reasonable time after the external reviewer or court rejected the claim for immediate review (but not to exceed ten days). Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

B. Failure to Follow the Claims Procedure for Disability Benefits Claims

Notwithstanding the in this exhibit, if the Plan fails to strictly adhere to the claims procedures for disability benefits claims, the Claimant will be deemed to have "exhausted" all administrative remedies available under the Plan. The Claimant will then be entitled to bring an action under Section 502(a) of ERISA on the basis that the Plan failed to provide the Claimant with a reasonable claims procedure that would yield a decision on the merits of the Claimant's claim. If the Claimant chooses to bring an action under Section 502(a) of ERISA in these circumstances, the Claimant's claim or the Claimant's appeal of the Claimant's claim denial will be deemed to have been denied by the Plan on review.

Notwithstanding the in this exhibit paragraph, the administrative remedies available under the Plan will not be deemed to have been “exhausted” based on minor violations that do not cause and are not likely to cause the Claimant to be prejudiced or harmed in any way, provided the Plan shows that the violation was for a good cause or due to matters beyond its control, and that the violation occurred in the context of an ongoing, good faith exchange of information between the Claimant and the Plan. This exception is not available to the Plan if the violation is part of a pattern or practice of violations by the Plan.

The Claimant may request a written explanation of the violation from the Plan. The Plan must provide the requested explanation within 10 days, including a specific description of the bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted.

If a court rejects the Claimant’s request for immediate review on the basis that the Plan met the standards for the exception, the claim will be considered to be re-filed on appeal upon the Plan’s receipt of the decision of the court. The Plan will provide a notice of the resubmission to the Claimant within a reasonable time after the receipt of the decision.