ST. JOHN’S UNIVERSITY

Point-of-Service Plan

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Effective January 1, 2014
# TABLE OF CONTENTS

INTRODUCTION .............................................................................................................................. 1

COVERAGE PROVIDED BY THE PLAN .......................................................................................... 1

SUGGESTIONS FOR USING THIS SPD ......................................................................................... 2

WHOM TO CALL FOR HELP OR INFORMATION ........................................................................... 3

ELIGIBILITY: HOW AND WHEN COVERAGE BEGINS, IS MAINTAINED, AND ENDS .................. 6

   ELIGIBILITY FOR COVERAGE .................................................................................................. 6
   WHEN COVERAGE STARTS ......................................................................................................... 12
   SPECIAL RULES FOR COVERAGE AND ENROLLMENT .......................................................... 13
   PAYMENT FOR COVERAGE .................................................................................................... 17
   CHANGING YOUR COVERAGE DURING THE YEAR ............................................................... 18
   WHEN COVERAGE ENDS ......................................................................................................... 20

CLAIMS PROCEDURE .................................................................................................................. 26

   FILING A CLAIM ..................................................................................................................... 26
   WHEN CLAIMS SHOULD BE FILED ....................................................................................... 26

CLAIM REVIEW PROCEDURE ................................................................................................... 27

   INITIAL CLAIM DETERMINATIONS ...................................................................................... 27
   CONCURRENT CARE DECISIONS ............................................................................................ 28
   INCOMPLETE CLAIMS NOTIFICATION .................................................................................. 29
   EXTENSIONS OF TIME .......................................................................................................... 29
   APPEAL PROCESS .................................................................................................................. 30

COBRA CONTINUATION COVERAGE ....................................................................................... 35

   WHAT COBRA CONTINUATION COVERAGE IS .................................................................... 35
   WHO IS ENTITLED TO COBRA CONTINUATION COVERAGE (THE QUALIFIED BENEFICIARY); WHY (THE QUALIFYING EVENT); AND FOR HOW LONG? ................................................................. 35
   WHEN THE PLAN MUST BE NOTIFIED OF A QUALIFYING EVENT .................................... 37
   NOTICE YOU WILL RECEIVE WHEN ENTITLED TO COBRA COVERAGE .... 37
   COBRA CONTINUATION COVERAGE THAT WILL BE PROVIDED ........................................ 37
   PAYING FOR COBRA CONTINUATION COVERAGE .......................................................... 38
   EXTENDED COBRA CONTINUATION COVERAGE ............................................................. 39
   ADDITION OF NEWLY ACQUIRED DEPENDENTS ................................................................. 40
   WHEN COBRA CONTINUATION COVERAGE MAY BE CUT SHORT .................................... 40
   ENTITLEMENT TO CONVERT TO AN INDIVIDUAL HEALTH PLAN ..................................... 41
   WHOM TO CONTACT IF YOU HAVE QUESTIONS OR TO GIVE NOTICE OF CHANGES IN YOUR CIRCUMSTANCES .................................................................................................................... 42
INTRODUCTION

COVERAGE PROVIDED BY THE PLAN

A. This document, together with a separate booklet (titled “Guide to Your Oxford Coverage” and described in more detail in paragraph (C below), is the summary plan description (hereafter the “SPD”) that make up the St. John’s University Point-of Service Plan (hereafter the “Plan”) provided by St. John’s University for all full-time employees and certain retirees of St. John’s University and its affiliates (hereafter collectively referred to as the “University”). Some of the details of the Plan are set forth in this SPD, and some of the details of the Plan are set forth in the Guide to Your Oxford Coverage.

B. The University reserves the right, subject to applicable collective bargaining agreements, to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

C. The Guide to Your Oxford Coverage is a separate booklet that provides details about the Plan which may not be included in this document. The Plan is referred to in some parts of the Guide to Your Oxford Coverage as the “Freedom Plan Select.” You should review the following parts of the Guide to Your Oxford Coverage for more information about the Plan:

- “How the Plan Works”
- “Medical Emergencies & Urgent Care”
- “Transitional Care”
- “Initial Coverage Determination Timeframes”
- “Appeals, Grievances and Complaints”
- “ERISA Information”
- “How Covered Services are Reimbursed”
- “Notification of Federal Legislation”
- “Evaluating New Medical Technology”
- “Participant Rights and Responsibilities”
- “Information on the Web”
- “Information Available Upon Request”
- An additional document providing further Summary Plan Description (SPD) information from Oxford follows.

These documents are hereby incorporated by reference and made a part of this Plan. Copies of the Guide to Your Oxford Coverage are available upon request of the Plan Administrator or on the University website at: http://www.stjohns.edu/faculty/hr/benefits.

D. It is possible that the Plan will change from time to time, or that a different insurer or administrator will be designated. If and when that occurs, every employee who is a Plan Participant or eligible to become one, will be given, at no cost, up-to-date information that clearly describes the changes to the Plan, the new insurer or administrator of the Plan, and the identification of each booklet or chapter of this SPD that sets forth the terms and provisions of the Plan.
E. Each employee of the University is eligible to enroll himself or herself and each of his or her Eligible Dependents, in the Plan. Details of the Plan are provided in the booklets or chapters of this SPD and the Guide to Your Oxford Coverage, and the rules for eligibility and enrollment are provided in the Eligibility chapter of this SPD.

SUGGESTIONS FOR USING THIS SPD

This SPD provides information about your Plan. You and each of your covered family members should take the following steps to become familiar with what is included in it:

A. Read through this Introduction chapter and look at the Table of Contents that immediately precedes it. The Quick Reference Chart at the end of this Introduction chapter identifies the people who can answer your questions about the Plan. The Table of Contents provides you with an outline of the topics covered within each chapter of this document.

B. Review the Guide to Your Oxford Coverage that describe your benefits in more detail. It describes the limitations or exclusions applicable to those benefits, and the terms of provisions of the coverage provided by the Plan. Remember, not every expense you incur for health care is covered by the Plan. To be sure you and your covered family members understand the benefits provided by this Plan, you and your family members should review this SPD and the Guide to Your Oxford Coverage. As you look through the text, you will notice that there are examples, charts and tables to help clarify the key provisions and more technical details of your medical coverage. As you review this document and the Guide to Your Oxford Coverage:

1. Be sure you understand defined terms. These documents use many technical terms that appear in the text with initial capital letters. If you see a term that you do not understand, the page on which the term is defined is indicated in the Index under the heading, “Definitions.”

2. Refer to the Eligibility chapter for information about eligibility for coverage, the enrollment processes, and when coverage starts. It also explains special rules for coverage of newborn and adopted dependent children, and for when you and any of your dependents both work for the University. It also explains what Qualified Medical Child Support Orders (“QMCSOs”) are and how they operate. It then explains how you must pay for your coverage and when you may change your coverage during a Plan Year. It tells you when coverage ends, and how leaves of absences affect your coverage.

3. Refer to the Guide to Your Oxford Coverage to find out what you must do to file a claim and how to appeal or seek review of a claim determination if you are dissatisfied with it. For more detailed information about the procedures for submitting claims or seeking an appeal or review of claim determinations for all of
the benefit options (“Programs”), contact the Issue Resolution Department, Oxford Health Plans, 48 Monroe Turnpike, Trumbull, CT 06611.

4. Refer to the information in the Guide to Your Oxford Coverage for information regarding the handling of situations where you have coverage under more than one group health care plan, Medicare and other government plans (including personal injury protection under mandatory no-fault automobile insurance coverage), workers’ compensation, or where you can recover your medical expenses from a third party who wrongfully caused the injury or illness giving rise to those expenses.

5. **If coverage ends for you or a covered Spouse or Dependent Child, see the chapter of this document titled COBRA Continuation Coverage.** which explains when your coverage may be continued after it ends. The Guide to Your Oxford Coverage explains if and when your coverage may be extended for a period of time, but this document contains up-to-date information about your right to continue your medical coverage under the federal law known as COBRA.

6. Refer to the Other Information chapter for information regarding your rights and the University’s rights under the law and with respect to the Plan.

C. All the information in this document and the Guide to Your Oxford Coverage is important, and it is your responsibility to understand it. However, some provisions in this document include the notation “(Very Important Information)” in their headings because they explain very important obligations that you must satisfy in order to preserve your rights under the Plan, or because they explain certain very important limitations of the liability of the Plan and the University. All other provisions also explain your rights under the Plan and explain limitations of liability of the Plan and the University. **The use of this notation in the headings of some provisions should not lead you to assume that other provisions do not contain very important information as well.** If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information. A Quick Reference Chart that identifies sources of help or information about the Plan appears at the end of this Introduction chapter.

D. As this Plan is amended from time to time, the University will send you information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

E. Be sure to keep this SPD, consisting of this document and the Guide to Your Oxford Coverage, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

WHOM TO CALL FOR HELP OR INFORMATION
A. When you need information, please check this document first. If you need further help, call the person listed in the following Quick Reference Chart who is identified as the contact for the question or problem you have. If it isn’t clear who that is, call the contact for general information.

B. It is possible that this Plan will change from time to time, or that the insurer or administrator of that Program will change. At each Open Enrollment Period, or whenever a material modification is made, every employee who is a Plan Participant or eligible to become one will be given within a reasonable period of time, at no cost, an up-to-date version of this Quick Reference Chart that clearly shows the Programs available and the person or office to contact for any of the matters indicated. Always consult the Quick Reference Chart for the current year. If you can’t find your copy of it, call the Plan Administrator at 718-990-6587 for a new copy of it.
# Quick Reference Chart

<table>
<thead>
<tr>
<th>Information Needed</th>
<th>Whom to Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Information About the Plan</strong></td>
<td><strong>Plan Administrator</strong></td>
</tr>
<tr>
<td>• Eligibility for Coverage</td>
<td>Employee Benefits Office</td>
</tr>
<tr>
<td>• Enrollment Forms</td>
<td>St. John’s University</td>
</tr>
<tr>
<td>• Plan Benefit Information</td>
<td>8000 Utopia Pkwy</td>
</tr>
<tr>
<td>• Adding or Dropping Dependents</td>
<td>Jamaica, New York 11439</td>
</tr>
<tr>
<td>• Copies of Documents</td>
<td>Phone: 718-990-6587</td>
</tr>
<tr>
<td>• QMCSO Information</td>
<td>Fax: 718-990-5887</td>
</tr>
<tr>
<td>• COBRA Information</td>
<td>Web Site: <a href="http://www.stjohns.edu">www.stjohns.edu</a></td>
</tr>
<tr>
<td>• Certification of Creditable Coverage</td>
<td></td>
</tr>
</tbody>
</table>

**Important Notice:** You or your Dependents must promptly furnish to the Plan Administrator information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in status of a Dependent Child, Medicare enrollment or disenrollment or the existence of other medical coverage. Failure to do so may cause you or your Dependents to lose certain rights under the Plan. See the Other Information chapter for more details regarding this requirement.

<table>
<thead>
<tr>
<th><strong>Oxford Health Plans</strong></th>
<th><strong>COBRA Continuation Coverage</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Customer Services</strong></td>
<td><strong>Information About Coverage</strong></td>
</tr>
<tr>
<td>• Provider Directories</td>
<td>Discovery Benefits</td>
</tr>
<tr>
<td>• Additions/Deletions of Providers</td>
<td>P.O. Box 2079</td>
</tr>
<tr>
<td>Medical Emergencies and Urgent Care</td>
<td>Omaha, NE 68108-2079</td>
</tr>
<tr>
<td>Phone: 800-444-6222</td>
<td>Telephone: 866-451-3399</td>
</tr>
<tr>
<td>After 5:00 PM: 800-889-9039</td>
<td></td>
</tr>
</tbody>
</table>
ELIGIBILITY: HOW AND WHEN COVERAGE BEGINS, IS MAINTAINED, AND ENDS

ELIGIBILITY FOR COVERAGE

A. Your Eligibility For the Oxford Point of Service Plan

You are eligible to participate in the Plan if you are an employee of the University, paid from the University’s regular payroll and scheduled to work on a full-time basis (an “Eligible Employee”). An employee is considered to be working on a full-time basis if he or she is working at least 30 hours per week. **You must enroll in the Program to be covered.**

B. Your Dependents’ Eligibility

If you elect coverage for yourself, your Eligible Dependents may be enrolled for coverage as well. **You must enroll your Eligible Dependents in each Program in which you want them to be covered.**

C. Who Your Eligible Dependents Are

1. **Eligible Dependent:** An “Eligible Dependent” includes your Spouse and Dependent Child(ren). An Eligible Dependent may be enrolled by following the procedures required by the Plan as described below. Once an Eligible Dependent is enrolled for coverage under the Plan, coverage begins in accordance with the terms and provisions described below, and that person becomes a covered Dependent and remains a covered Dependent until his or her coverage ends in accordance with the terms and provisions of this Plan and the Program in which he or she is enrolled.

   Effective February 1, 2014, you must submit proof of Eligible Dependent status upon enrollment for coverage. Examples of acceptable proof include copies of marriage certificates, birth certificates, legal decrees, etc. If you are enrolling a Dependent Child between the ages of 26 and 35, you must also provide proof that the Dependent Child attends an accredited college, university or vocational school (as determined by the University) on a full-time basis (that is, takes at least 12 undergraduate or nine graduate credit hours of courses).

2. **Spouse:** A “Spouse” means the individual to whom you are married pursuant to a valid legal marriage under the law of the state or other jurisdiction where the marriage took place. A domestic partner is not a Spouse.

3. **Dependent Child(ren):** For the purposes of this Plan, a “Dependent Child” is any of your children, including any natural born child, stepchild, legally adopted child or child who is placed with you for adoption, eligible foster child (as defined under Internal Revenue Code Section 152(f)), or any such child for whom you are legally obligated to provide care and support; provided:
• the child has not reached his or her 26th birthday; or
• the child has reached his or her 26th birthday but has not reached his or her 35th birthday and is registered in and attends an accredited college, university or vocational school (as determined by the University) on a full-time basis (that is, takes at least 12 undergraduate or nine graduate credit hours of courses). The University may request documentation of full-time student status.

If the Dependent Child is under age 26, coverage will end at the end of the calendar year in which that child reaches his or her 26th birthday.

If the Dependent Child is age 26 or over, coverage will end at the end of the calendar year in which that child:

• reaches his or her 35th birthday;
• terminates full-time attendance at an accredited college or vocational school voluntarily, as a result of graduation, or involuntarily;
• marries;
• enters military or similar service anywhere; or
• becomes employed on a full-time basis by one or more employers.

Coverage of a Dependent Child may continue after the child has reached his or her 26th or 35th birthday for any child who has a “Handicap.” A Dependent Child has a Handicap if he or she is mentally or physically handicapped and, as a result, is:

• incapable of self-sustaining employment; and
• dependent chiefly on you and/or your Spouse for support and maintenance.

D. Retiree Coverage

To qualify for retiree coverage, you must meet the following eligibility criteria:

• You are an active, full-time staff or administrative employee and, at the time you retire from the University, you are at least 55 years of age and have a minimum of 10 years of full-time service with the University, and the sum of your age and years of service with the University totaled 75 years or more; or

• You are an active, full-time faculty employee and, at the time you retire from the University, you are at least 65 years of age or you are granted early retirement benefits pursuant to the applicable collective bargaining agreement.

In addition, if you were not already covered under the Plan, you will be able to enroll for medical coverage under the Plan during the next Open Enrollment Period as long as:

• You meet the retiree coverage eligibility criteria described above; and
• You are enrolled in any other welfare benefit plan (i.e., dental).
The surviving Spouse of a retiree covered under the Plan may elect to continue coverage under the Plan at his or her own expense.

E. Eligibility Under Separation Agreements

In addition you may be eligible to participate in the Plan after your employment terminates (even though you are not eligible for retiree coverage) if in connection with your termination you entered into a Separation Agreement with the University that expressly states that you (and your dependents, if applicable) are eligible to participate in the Plan. Please note that not all Separation Agreements provide for continuing eligibility following termination of employment.

F. Eligibility During Certain Disability Leaves

Under certain limited circumstances, you may continue to be eligible to participate in the Plan during an approved long-term disability, under the same terms and conditions as an active employee, for a maximum period of 18 months (measured from the date of the approved long-term disability leave). Moreover, in the case of an administrative employee (and only administrative employees) who is not eligible for retiree coverage immediately following the 18-month disability leave coverage discussed above, the employee may be eligible to continue coverage under the Plan – at the employee’s own expense – as long as he or she (i) was working a minimum of 30 hours per week and has completed at least 25 years of service with the University, at the time he or she first became disabled (i.e., approved short-term disability leave); (ii) has been disabled for at least 24 months (including both short-term and long-term disabilities); and (iii) is disabled for purposes of the University’s long-term disability plan. The University will contact you at the appropriate time if you are eligible to participate in the Plan as described above.

ENROLLMENT FOR COVERAGE

A. Enrollment Is Required for Coverage

You and/or your Eligible Dependents may become covered by this Plan only if you submit a completed written enrollment form, which may be obtained from the Employee Benefits Office, on a timely basis as described below. Any person who is not duly enrolled cannot be covered under this Plan and will have no right to any coverage for benefits or services under this Plan (unless otherwise required by law).

Effective February 1, 2014, you must submit proof of Eligible Dependent status upon enrollment for coverage. Examples of acceptable proof include copies of marriage certificates, birth certificates, legal decrees, etc. If you are enrolling a Dependent Child between the ages of 26 and 35, you must also provide proof that the Dependent Child attends an accredited college, university or vocational school (as determined by the University) on a full-time basis (that is, takes at least 12 undergraduate or nine graduate credit hours of courses).
B. Initial Enrollment

1. Initial Enrollment Period and Procedure

To be covered by this Plan, you must enroll, no later than 31 days after the date your coverage is scheduled to start, as described in this ENROLLMENT FOR COVERAGE section of the SPD, by submitting a completed written enrollment form (which may be obtained from the Employee Benefits Office). Evidence of insurability is not required for initial enrollment in this Plan.

The following rules apply with respect to enrollment:

- If you want Dependent coverage, you must enroll your Eligible Dependents at the same time that you enroll by submitting a completed written enrollment form (which may be obtained from the Employee Benefits Office) and providing any required documentation to prove the individual’s status as an Eligible Dependent.
- No person can be covered both as an Employee and as a Dependent.
- If you and your Spouse are both Eligible Employees, only one of you may enroll your Dependent Child(ren) as Dependents. See the section titled When You and Any of Your Dependents Both Work for the University for further information.

2. Failure to Enroll During Initial Enrollment (Very Important Information)

If you do not enroll yourself and/or any of your Eligible Dependents for medical coverage during the initial enrollment period, late enrollment will not be allowed until the next annual Open Enrollment Period, unless you and/or your Eligible Dependent(s) qualify for the “Special Enrollment” as explained in the section titled Special Enrollment immediately below.

C. Special Enrollment

1. Newly Acquired Spouse and/or Dependent Child(ren)

- If you are enrolled for individual coverage and if you subsequently marry or acquire any Dependent Child(ren) by birth, adoption or placement for adoption, you may enroll your newly acquired Spouse and/or any such newly acquired Dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption. Enrollment forms may be obtained from the Employee Benefits Office.

- If you are not enrolled for individual coverage and if you subsequently marry or acquire any Dependent Child(ren) by birth, adoption or placement for adoption, you may enroll yourself, you may also enroll your newly acquired
Spouse and/or any such newly acquired Dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption.

- If you did not enroll your Spouse for coverage within 31 days of the date on which he or she became eligible for coverage, and if you subsequently acquire a Dependent Child by birth, adoption or placement for adoption, you may enroll your Spouse together with your newly acquired Dependent Child no later than 31 days after the date of your newly acquired Dependent Child’s birth, adoption or placement for adoption.

2. Loss of Other Medical Coverage

If you did not enroll yourself, your Spouse and/or any Dependent Child(ren) for medical coverage within 31 days after the date on which you or they first became eligible for coverage because you and/or they were covered by another plan, and you, your Spouse and/or any Dependent Child(ren) cease to be covered by that other plan, you may enroll yourself and/or that Spouse and/or Dependent Child(ren) within 31 days after the termination of their coverage under that other plan if that other coverage terminated because:

- of the loss of eligibility for that other coverage as a result of termination of employment or reduction in the number of hours of employment, or death, divorce or legal separation;
- of the termination of employer contributions toward that other coverage; or
- that other coverage was “COBRA Continuation Coverage” and it was Exhausted.

COBRA Continuation Coverage is “Exhausted” if it ceases for any reason other than either the failure of the individual to pay the charge for the COBRA Continuation Coverage on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with that COBRA Continuation Coverage). Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:

- due to the failure of the employer or other responsible entity to remit premiums on a timely basis;
- when the employer or other plan sponsor entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;
- when the individual no longer resides in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or
- because the 18-month or 36-month period of COBRA Continuation Coverage has expired.

3. Failure to Enroll During Special Enrollment
(Very Important Information)

If you do not enroll yourself and/or any of your Eligible Dependents within 31 days after the date on which you and/or they first become eligible for Special Enrollment, you will not be able to enroll them until the next Open Enrollment Period.

4. **Children’s Health Insurance Program**

Pursuant to the Children’s Health Insurance Program Reauthorization Act of 2009 (“CHIP”), an Eligible Employee and/or Eligible Dependent who is eligible for (but not enrolled in the Plan) may enroll at any time during the Plan year as follows:

- The Eligible Employee and/or the Eligible Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, and the Eligible Employee or requests coverage under the Plan not later than 60 days after the date the Eligible Employee or Eligible Dependent is first determined to be eligible for such assistance; or

- The Eligible Employee’s and/or Eligible Dependent’s Medicaid or CHIP coverage has terminated as a result of loss of eligibility for such coverage, and the Eligible Employee requests coverage under the Plan not later than 60 days after the date of termination of such coverage.

D. **Open Enrollment**

1. **Open Enrollment Period**

Prior to the start of each Plan Year, a period of time called the “Open Enrollment Period” will be designated by the University during which each employee will have the opportunity to make changes in coverage under the Plan. At the start of the Open Enrollment Period, each Employee will be given enrollment forms and current information about the Plan and the required contributions for coverage.

2. **Elections Available During Open Enrollment**

During the Open Enrollment Period, you may elect, for yourself and your Eligible Dependents who are enrolled for coverage, to:

- enroll in the Plan if you have not yet already done so, subject to the terms and conditions explained in the booklet or chapter describing the medical plan; or
- add Eligible Dependents to coverage under the Plan; or
- discontinue medical coverage for yourself and/or any of your Dependents.

3. **Restrictions on Elections During Open Enrollment**

No Dependent may be covered under the Plan unless you are also covered under it.
All relevant parts of the enrollment form must be completed, and the form must be submitted to the Employee Benefits Office, before the end of the Open Enrollment Period.

4. Failure to Make a New Election During Open Enrollment

If you have been enrolled for coverage and you do not make a new election during the Open Enrollment Period, you will be considered to have made an election to retain coverage under the Plan and to continue to make your contributions toward the cost of that coverage through a reduction in your pay.

5. Failure to Enroll During Open Enrollment
   (Very Important Information)

   If you were not already covered under the Plan and do not enroll yourself and/or any of your Eligible Dependents in the Plan during the Open Enrollment Period, unless you and/or your Eligible Dependents qualify for the Special Enrollment described in the Special Enrollment section of this subchapter above, you will not be able to enroll yourself and/or them for medical coverage until the next Open Enrollment Period.

WHEN COVERAGE STARTS

A. Start of Coverage Following Initial Enrollment

   If you have submitted a completed written enrollment form during the Initial Enrollment Period on a timely basis:

   1. Start of Your Coverage

      Your coverage starts on the first day of the month coincident with your first day of employment if you are Actively at Work on the first of that month. Otherwise your coverage starts on the first of the month following, provided you are Actively at Work on that date. “Actively at Work” means that you are present at your work location and actually performing all the essential duties required by your job during that entire day. However, this Actively at Work requirement does not apply, with respect to medical coverage, if the reason why you are not Actively at Work is because you have a sickness or injury that prevents you from being Actively at Work. The period between the start of employment and the start of coverage is referred to as the “Waiting Period.”

      Please note that, if your employment with the University is terminated and you are subsequently rehired, you will be treated as a new hire. Therefore, you will be required to satisfy all eligibility, enrollment, and Waiting Period requirements upon rehire.
2. Start of Dependent Coverage

An “Initial Dependent” is a Spouse or Dependent Child who was an Eligible Dependent on the date that you first became eligible for employee coverage. A “Subsequent Dependent” is a family member who became your Spouse or Dependent Child after the date you first became eligible for employee coverage.

Coverage of your Initial Dependents starts on the date your coverage starts.

Rules applicable to the start of medical coverage of your Subsequent Dependents are described in the section immediately below.

B. Start of Coverage Following Special Enrollment

If you have submitted a completed written enrollment form for Special Enrollment within 31 days after the event that created the special enrollment opportunity:

1. Except with respect to coverage of a newborn or newly adopted Dependent Child, your coverage, your Spouse’s coverage, and/or the coverage of any of your other Dependent Child(ren) will become effective as of the date of the event that created the Special Enrollment opportunity.

2. Coverage of a newborn or newly adopted Dependent Child who is enrolled with 31 days after birth will become effective as of the date of the child’s birth.

3. Coverage of a newly adopted Dependent Child who is enrolled more than 31 days after birth, but within 31 days after the child is adopted or placed for adoption will become effective as of the date of the child’s adoption or placement for adoption, whichever occurs first.

C. Start of Coverage or Changes to Coverage Following Open Enrollment

1. If you or your Spouse or Dependent Child(ren) are enrolled for coverage under the Plan for the first time during an Open Enrollment Period, coverage will start on the first day of the Plan Year following the Open Enrollment Period.

SPECIAL RULES FOR COVERAGE AND ENROLLMENT

A. Newborn Dependent Children

If you have elected coverage under the Plan, your newborn Dependent Child(ren) will be covered under the Plan from the date of birth, but only if you enroll that newborn Dependent Child for coverage within 31 days after the child’s date of birth and you pay any required contribution for that Dependent Child’s coverage.
B. Adopted Dependent Children

1. If you have elected coverage under the Plan, your adopted Dependent Child will be covered under the Plan from the date that child is adopted or Placed for Adoption with you, but only if you enroll that newly adopted Dependent Child for coverage within 31 days after the date of adoption or placement for adoption (or in the case of a newborn adopted child, that child’s date of birth) and, in all cases, you pay any required contribution for that Dependent Child’s coverage.

2. A child is “Placed for Adoption” with you on the date you first become legally obligated to provide full or partial support for the child whom you plan to adopt.

3. A child who is Placed for Adoption with you within 31 days after the child was born will be covered from birth if you comply with the Plan’s requirements for obtaining coverage for a newborn Dependent Child.

4. However, if a child is Placed for Adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.

C. When You and Any of Your Dependents Both Work for the University

1. If you and your Spouse are both employees of the University, you may provide coverage for yourself and your covered Dependents in one of two ways:

- One of you must be designated as the covered employee who can make the enrollment choices for the entire family, including the other employee as a Spouse, and all Dependent Children. If this choice is elected, the spouse who is not designated as the Eligible Employee may not make any independent coverage election under the Plan.
- Each of you may elect your own coverage as an employee. If this choice is elected, only one of you may cover your Dependent Child(ren).

If the employee-spouse who elected coverage as an employee terminates employment or has a reduction in hours that would ordinarily result in a termination of coverage, the employee who was covered as a Spouse will immediately be deemed to have employee coverage, and the employee who had employee coverage will immediately be deemed to be covered as a Spouse, and all Dependent Children will retain their coverage as Dependents of the employee-spouse. Contributions for Dependent coverage will be deducted from the pay of the employee-spouse who is then deemed to be the covered employee. As a result, neither employee will sustain a loss of coverage because of termination of employment or reduction in hours.

The employee-spouse who is then deemed to be the covered employee will have the option to terminate the coverage of the Spouse and/or any Dependent Child or otherwise to elect any alternative coverage available under the Plan for the family
members provided such election is, in the judgment of the Plan Administrator or its
designee, consistent with the change in the family’s circumstances as a result of the
termination of employment or reduction in hours.

2. If, while your family coverage is in effect, any of your Dependent Children
becomes an employee of the University and becomes eligible for coverage as an
employee:

- If the employee-child terminates employment or has a reduction in hours that
  would ordinarily result in a termination of coverage, and still qualifies as a
  Dependent Child, the employee-child will immediately be deemed to be
  covered as a Dependent Child of the employee-parent. As a result, the
  employee-child will not sustain a loss of coverage because of termination of
  employment or reduction in hours. Contributions for Dependent coverage will
  be deducted from the pay of the employee-parent, and will be adjusted as may
  be required when a Dependent Child becomes an employee and elects to have
  coverage as an employee rather than as a Dependent Child, or when the
  employee-child ceases to be an employee and resumes coverage as a Dependent
  Child.

E. Qualified Medical Child Support Orders (“QMCSOs”)

1. According to federal law, a Qualified Medical Child Support Order (hereafter
   “QMCSO”) is an order of a court or state administrative agency that is received by
   the Plan. It usually results from a divorce or legal separation. A QMCSO:

   - Designates one parent to pay for a child’s health plan coverage and/or creates or
     recognizes the right of an “alternate recipient” (usually the custodial parent or a
     Health Care Provider) to receive the Plan’s medical benefits;
   - Indicates the name and last known address of the parent required to pay for the
     coverage and the name and mailing address of each child covered by the
     QMCSO;
   - Contains a reasonable description of the type of coverage to be provided under
     the designated parent’s health care plan or the manner in which such type of
     coverage is to be determined;
   - States the period for which the QMCSO applies; and/or
   - Identifies each health care plan to which the QMCSO applies.

2. An order is not a QMCSO if it requires the Plan to provide any type or form of
   benefit or any option that the Plan does not otherwise provide, or if it requires an
   employee who is not covered by this Plan to provide coverage for a Dependent
   Child, except to the extent necessary to meet the requirements of a state’s
   Medicaid-related child support laws. For a state administrative agency order to be a
   QMCSO, state statutory law must provide that such an order will have the force and
effect of law, and the order must be issued through an administrative process
established by state law.
3. If a court or state administrative agency has issued an order with respect to health care coverage for any of the employee’s Dependent Children, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law, and that determination will be binding on the employee, the other parent, the child and any other party acting on behalf of the child. If an order is determined to be a QMCSO, and if the employee is covered by this Plan, the Plan Administrator or its designee will so notify the parents and each child, and advise them of the Plan’s procedures that must be followed to provide coverage of the Dependent Child(ren).

4. If the employee is a participant in the Plan, the QMCSO may require the Plan to provide coverage for the employee’s Dependent Child(ren) and to accept contributions for that coverage from a parent who is not a Plan participant (usually the custodial parent). In such a case, the Plan will accept a Special Enrollment of the Dependent Child(ren) as specified by the QMCSO from either the employee or the custodial parent. Coverage of the Dependent Child(ren) shall become effective as of the date the enrollment is received by the Plan, and shall be subject to all of the terms and provisions of the Plan, including (without limitation) limits on selection of provider and requirements for authorization of services, insofar as is permitted by applicable law.

5. If the employee is not a participant in the Plan at the time the QMCSO is received, and the QMCSO orders the employee to provide coverage for the Dependent Child(ren) of the employee, the Plan will accept a Special Enrollment of the employee and the Dependent Child(ren) as specified by the QMCSO. Coverage of the employee and the Dependent Child(ren) shall become effective as of the date the enrollment is received by the Plan, and shall be subject to all of the terms and provisions of the Plan, including (without limitation) limits on selection of provider, and requirements for authorization of services, insofar as is permitted by applicable law.

6. No coverage will be provided for any Dependent Child under a QMCSO unless the applicable employee contributions for that Dependent Child’s coverage are paid, and all of the Plan’s requirements for coverage of that Dependent Child have been satisfied. Contributions required for coverage under a QMCSO are the total cost of coverage of the employee and all members of the employee’s family who are enrolled in the Plan, minus the contributions otherwise actually being paid by the employee and the University. Required contributions will be withhold from an employee’s pay, unless prohibited by federal or state withholding limitations. If an employee disagrees with the required withholding, he or she may appeal to the agency or court responsible for issuing the QMCSO.

7. Coverage of a Dependent Child under a QMCSO will terminate when coverage of the employee-parent terminates for any reason, including failure to pay any
required contributions, subject to the Dependent Child’s right to elect COBRA Continuation Coverage if that right applies.

8. **All determinations of whether or not a court order is a QMCSO will be made by the University.** If you disagree with that determination, you may file a written request for a review of it with the Plan Administrator within 30 days after you are notified of that determination. When you do so, you will be advised of your right to submit additional information or evidence, and how to do it. You will be advised of a decision on your request for review within 30 days after the period during which you may submit additional information or evidence in support of your request for review.

9. A QMCSO may require the Plan to pay Plan benefits on account of expenses incurred by or on behalf of the Dependent Child(ren) covered by this Plan either to the Health Care Provider who rendered the services or to the custodial parent of the Dependent Child(ren). If coverage of the Dependent Child(ren) is actually provided by the Plan, and if the Plan Administrator or its designee determines that it has received a QMCSO, it will pay Plan benefits on account of expenses incurred by or on behalf of the Dependent Child(ren) to the extent otherwise covered by this Plan as required by that QMCSO.

A copy of the Plan’s procedures can be obtained from the Plan Administrator, free of charge.

**PAYMENT FOR COVERAGE**

A. **For Administrators, Staff and Law School Faculty Employees Hired After June 1, 2000 and Faculty Employees Hired After August 31, 2003**

You must contribute towards the cost of coverage for both you and your Dependents under the Plan. The specific contributions you must pay for the coverage you elect can be determined from the chart that is provided to you at no cost, along with other Open Enrollment information material, at the start of each Open Enrollment Period.

B. **For Administrators, Staff and Law School Faculty Employees Hired On or Before June 1, 2000 and Faculty Employees Hired Before September 1, 2003**

- **Employee Coverage**

  The University will pay the entire cost of coverage for you under the Plan. The University sets the level of any employee contributions and reserves the right to change these levels at any time.

- **Dependent Coverage: Administrators, Staff and Law School Faculty Employees hired on or before June 1, 2000**
You must contribute towards the cost of coverage for your Dependents under the Plan. The specific contributions you must pay for the coverage you elect for your Dependents can be determined from the chart that is provided to you at no cost, along with other Open Enrollment information material, at the start of each Open Enrollment Period.

- **Dependent Coverage: Faculty Employees Hired Before September 1, 2003**

The University will share the cost of coverage for your Dependents under the Plan. You will have a choice regarding how this cost will be shared. You may choose either (i) to pay the difference between the full cost of family coverage and the full cost of individual coverage for two consecutive years after which time the University will pay the full cost of coverage for your Dependents, or (ii) to pay a portion of the cost of coverage for your Dependents in an amount determined by the University each year. In both cases, the amount you will pay can be determined from the chart that is provided to you at no cost, along with other Open Enrollment information material, at the start of each Open Enrollment Period. The University sets the level of any employee contributions and reserves the right to change these levels at any time.

- **Retired Employees**

You must pay the entire cost of coverage under the Plan. As a Retired Employee, you must complete an application and remit payments directly to P&A Group. In addition, you can cancel your coverage, at any time, by notifying the P&A Group in writing.

**CHANGING YOUR COVERAGE DURING THE YEAR**

**When Coverage Changes Are Permitted**

Government regulations generally require that your elections of Plan coverage remain in effect throughout the Plan Year from January 1 through December 31, but you may be able to make changes that are necessary, appropriate to and consistent with the following qualifying changes in your work or family status:

1. **Change in legal marital status**, including marriage, divorce, legal separation, annulment, or death of a Spouse.

2. **Change in the number of Dependents**, including birth, adoption, placement for adoption or death.

3. **Change in your, your Spouse’s or Dependent Child(ren)’s employment status or work schedule**, including termination or commencement of employment, an increase or decrease in hours of employment (including a switch between part-time and full-time employment), a strike or lock-out, the start of or return from an unpaid leave of absence, or a change of work-site that impairs your, your Spouse’s or any Dependent Child’s ability to access services of In-Network Health Care Providers.
4. **Change in Dependent status** under the terms of this Plan, including changes due to attainment of age, loss of student status, or any other reason provided under the definition of Dependent in this SPD.

5. **Change of residence** that impairs your, your Spouse’s or any Dependent Child’s ability to access services of In-Network Health Care Providers.

6. **Change required under the terms of a Qualified Medical Child Support Order** (“QMCSO”), including any change necessary to add the child as a covered Dependent to provide the coverage specified in the order, or to cancel the child’s coverage if the order requires your former spouse to provide that coverage.

7. **Change consistent with your right to Special Enrollment** under this Plan if you declined coverage under this Plan for yourself and or any of your Eligible Dependents in the manner described in this SPD.

8. **Change consistent with entitlement to Medicare or Medicaid** (except for coverage solely under the program for distribution of pediatric vaccines), including prospective cancellation of coverage of you, your Spouse or any Dependent Child following entitlement to Medicare or Medicaid coverage, or prospective reinstatement or election of coverage following loss of eligibility for Medicare or Medicaid coverage.

9. **Any increase or decrease in contributions** required from all employees for coverage under this Plan.

10. **Significant increase in your cost for coverage** under this Plan.

11. **Significant curtailment or cessation of any program** under this Plan or your Spouse’s employer’s plan if the Plan Administrator or its designee determines it results in reduced coverage to all Plan Participants.

12. **Addition or elimination of any program** under this Plan or your Spouse’s employer’s plan, including the use by that plan of a different period of coverage or plan year.

The Plan Administrator or its designee has full discretion and authority to determine if the changes of elections you request are necessary, appropriate to and consistent with the applicable qualifying change in your work or family status, and if any increase in your cost for coverage or curtailment or cessation of any program is significant. The only changes in your elections under this Plan that the Plan Administrator or its designee, exercising the discretion and authority granted by the Plan, may allow with respect to the last three changes of status listed above will be to permit you:

- to have any applicable increases or decreases in your subsequent contributions for coverage continue through salary reduction; or
• to switch to another Program that the Plan Administrator or its designee determines to provide similar benefits.

WHEN COVERAGE ENDS

A. Events That Will Cause Your Coverage to End

1. Your coverage ends on the earliest of the last day of the month in which:
   • your employment ends; or
   • you no longer are eligible to participate in the Plan; or
   • you cease to make any contributions required for your coverage; or
   • the date the Plan is terminated.

2. Coverage for your covered Dependents ends on the earliest of the last day of the month in which:
   • your own coverage ends; or
   • your covered Spouse and/or Dependent Child(ren) no longer meet the definition of Spouse or Dependent Child(ren); or
   • you cease to make any contributions required for their coverage; or
   • the date the Plan is terminated.

3. You, your Spouse or any of your Dependent Children must notify the Plan, in writing, no later than 60 days after the date of:
   • a divorce or legal separation;
   • a Dependent Child:
     • reaches the Plan’s limiting age of 26 or 35; or
     • ceases to be a full-time student (over age 25); or
     • has any physical or mental Handicap; or
     • ceases to have any physical or mental Handicap (over age 25).

For more detailed information regarding Dependent Children, see the paragraph titled Dependent Children in the section titled Who Your Eligible Dependents Are. For more information regarding other notices you and/or your Dependents must furnish to the Plan, see the provision titled Information You or Your Dependents Must Furnish to the Plan in the Other Information chapter of this SPD.

B. Leaves of Absence

1. Family and/or Medical Leave. If you are covered by this Plan and have completed 12 months of employment, you are entitled by federal law to up to 12 weeks each 12 month period of unpaid family or medical leave for the specified family or medical purposes described below. While you are officially on such a family or medical leave, you can keep coverage under this Plan for yourself and
your Dependents in effect during that family or medical leave period by continuing to pay your contributions during that period. The St. John’s University Employee Handbook, Policy #502 describes the details of your rights under this law.

2. **Leave for Military Service.** If you go into active military service for up to 31 days, you can continue your coverage under this Plan during the leave period if you continue to pay your contributions for the coverage during the period of that leave. If you go into active military service for more than 31 days, you may be able to continue your coverage under this Plan at your own expense for up to 24 months under the Uniformed Services Employment and Reemployment Rights Act (USERRA). The St. John’s Employee Handbook, Policy #503 describes the details of your rights and the terms of a leave for military service.

3. **Reinstatement of Coverage After Other Leaves of Absence**
   - If your coverage under this Plan ends while you are on an approved leave of absence other than family, medical, long term disability or military leave, it will be reinstated as of the date required by law or on the first day of the month following your return to active service, if you return immediately after your leave of absence ends, subject to all accumulated out-of-pocket, overall and annual maximum Plan benefits that were incurred prior to the leave of absence.
   - Questions regarding your entitlement to a leave, other than for family, medical or military service purposes, and the terms on which you may be entitled to it should be referred to the Plan Administrator.

D. **Continuation of Medical Coverage**

Under certain circumstances, you may be able to continue your coverage under this Plan at your own expense for a limited period of time after it ends. See the chapter of this SPD titled COBRA Continuation Coverage for an explanation of if, when and how COBRA Continuation Coverage may apply to you and/or your Dependents.

E. **Certification of Creditable Coverage When Coverage Ends**

If your coverage under this Plan ends prior to December 31, 2014, you and/or your covered Dependents will be provided with a Certificate of Creditable Coverage, as required by federal law, that indicates the period of time you and/or they were covered by this Plan. Such a Certificate will be provided to you shortly after the Plan knows or has reason to know that coverage for you and/or your covered Dependent(s) has ended. In addition, such a Certificate will be provided when the Plan Administrator receives your request for one within two years after the date coverage ended, provided such request is made prior to December 31, 2014. As of December 31, 2014, the Plan will no longer provide Certificates of Creditable Coverage because of changes to federal law.
PLAN SUBROGATION AND REIMBURSEMENT

A. Acts of Third Parties

When you and/or your covered Dependent (“you”) are injured or become ill because of the action or inaction of a third party, the Plan may cover your eligible health care (e.g., medical, prescription drug, dental and vision) expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This Section describes the Plan’s procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else’s fault, the Plan has the right (but not the obligation) to “step into the shoes” of the person who is injured or ill and to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this Section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits, you agree that the Plan has rights of recovery, reimbursement and subrogation to the extent of any benefits paid for an illness or injury that is caused by a third party. You also agree that the Plan:

- Has a first priority equitable lien, including an equitable lien by contract, on any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- May appoint you as constructive trustee for any and all monies paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and
- May bring an action on its own behalf or on the covered person’s behalf against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this Section — through a judgment, settlement or otherwise — for an illness or injury that is caused by a third party, you agree to have the funds placed in a separate, identifiable account by you or the holder of the funds and that the Plan has an equitable lien on the funds, and you agree to serve as a constructive trustee over the funds to the extent the Plan has paid expenses related to that illness or injury.

You must pay the Plan back first, in full, out of such funds for any amounts the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the benefits you received from the Plan to the extent that you have received compensation from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses and regardless of any doctrines that may diminish the Plan’s right of recovery or reimbursement, including, but not limited to, the “make-whole doctrine.”
You must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

The Plan is not required to participate in or contribute to any expenses or fees (including attorney’s fees and costs) you incur in obtaining the funds. Any so-called “Common Fund Doctrine” or other similar doctrine shall not defeat this right.

The Plan’s sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;
- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers’ compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

- Cooperate with the Plan’s efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan’s subrogation or recovery rights.
- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Provide all information requested by the Plan, the Claims Administrator, the Plan Administrator or their authorized representatives.
- Execute and deliver such documents as may be required and do whatever else is needed to secure the Plan’s rights.

The Plan may terminate your Plan participation and/or offset your future benefits for the value of benefits advanced, if you do not provide the information, authorizations, or otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If these subrogation provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contract will govern. If these right of recovery provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the insurance contract will govern.
All Plan rights under this Section remain enforceable against the heirs and estate of any covered person.

B. Overpayment of Benefits

An “overpayment” is any payment made to you and/or your covered dependent (“you”) that is greater than the amount that should have been payable under the Plan. If you have cause to reasonably believe that an overpayment may have been made by the Plan, you must promptly notify the Plan Administrator of the relevant facts. If the Plan Administrator determines that an overpayment was made to you (or any other person), it will notify you in writing. You must promptly make payment for the amount of overpayment to (or cause another person to make payment to) the Plan Administrator. This Section describes the Plan’s procedures with respect to its right of recovery of overpayments.

By accepting Plan benefits, you agree that the Plan has rights of reimbursement to the extent that any benefits paid constitute an overpayment. You also agree that upon any overpayment, the Plan will have a first right of reimbursement and restitution with an equitable lien by contract in such amount. Furthermore, the holder of the overpayment shall hold it as the Plan's constructive trustee.

The Plan has the right to recover any overpayments including but not limited to placing a lien against the party that received the overpayment or reducing the amount of any outstanding benefit payments or any amounts subsequently payable as benefits under the Plan with respect to you by the amount of the outstanding overpayment.

You must pay the Plan back for any overpayment regardless of whether any third party admits liability, regardless of whether you have been made whole or fully compensated for your injury, regardless of whether any settlement or judgment says that the money you receive (all or part of it) is for health care expenses, and regardless of any doctrines that may diminish the Plan’s right of recovery or reimbursement, including, but not limited to, the “make-whole doctrine.”

The Plan is not required to participate in or contribute to any expenses or fees (including attorney’s fees and costs) you incur in obtaining funds that create an overpayment. Any so-called “Common Fund Doctrine” or other similar doctrine shall not defeat this right.

The Plan’s sources of payment through reimbursement or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive that create an overpayment;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive that create an overpayment;
- Any equitable lien on the portion of the total recovery which is due the Plan for the overpayment of benefits it paid; and

- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers’ compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives that causes an overpayment.

As a Plan participant, you are required to:

- Cooperate with the Plan’s efforts to ensure a successful subrogation or recovery claim of its overpayment, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan’s subrogation or recovery rights.

- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation that has caused or will cause an overpayment of Plan benefits.

- Provide all information requested by the Plan, the Claims Administrator, the Plan Administrator or their authorized representatives.

- Execute and deliver such documents as may be required and do whatever else is needed to secure the Plan’s rights.

The Plan may terminate your Plan participation and/or offset your future benefits for the value of benefits advanced, if you do not provide the information, authorizations, or otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If these right of recovery provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the insurance contract will govern.

All Plan rights under this Section remain enforceable against the heirs and estate of any covered person.
CLAIMS PROCEDURE

All health claims and appeals, as well as questions regarding health claims and appeals, shall be directed to Oxford Health Plans (the "Claims Administrator") pursuant to the procedures set forth below. The Claims Administrator is the named fiduciary with respect to appeals and has sole discretion to interpret the terms of the Plan as they relate to the Claims Administrator's determination of claims and appeals.

FILING A CLAIM

When a claimant has a claim to submit for payment, the claimant must follow the steps indicated below.

1. Obtain a claim form from the Director of Employee Benefits or the University website at: http://www.stjohns.edu.

2. Complete the Patient/Insured portion of the form. ALL QUESTIONS MUST BE ANSWERED.

3. Have the Physician complete the Physician/Supplier portion of the form.

4. Attach bills for services rendered. ALL BILLS MUST SHOW:
   - Your name.
   - Name of Plan.
   - Name of Patient.
   - Name, address, and telephone number of the care provider.
   - Diagnosis.
   - Type of services rendered, with codes for diagnosis and/or procedures.
   - Date of services.
   - Charges.

5. Send forms, bills, etc. to the Claims Administrator at the following address:

   Oxford Health Plans
   Customer Service
   PO Box 7082
   Bridgeport, CT 06601-7082
   Phone: 800-444-6222

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 90 days of the date that charges were incurred. Charges are considered incurred when treatment or care is given or a procedure performed. Benefits are based on the Plan’s provisions at the time the charges were incurred.
Claims filed later than 90 days after the date that charges were incurred may be reduced or even declined unless:

- it is not reasonably possible to submit the claim within the required time frame; and
- the claim is submitted within 180 days from the date incurred.

This 180-day period will not apply if the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to allow proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have the claimant seek a second medical opinion.

**CLAIM REVIEW PROCEDURE**

**INITIAL CLAIM DETERMINATIONS**

Provided the claimant follows the Plan’s claim filing procedures described above, the Plan will make an initial claim determination within:

- 72 hours after receipt of claim by the Plan in the case of an Urgent Care Claim
- 15 calendar days after receipt of claim by the Plan in the case of a Pre-Service Claim
- 30 calendar days after receipt of claim by the Plan in the case of a Post-Service Claim

An “Urgent Care Claim” is a claim for medical care with respect to which applying the time periods for making pre-service claims decisions could seriously jeopardize the claimant’s life, health or ability to regain maximum function or would subject the claimant to severe pain that cannot be adequately managed without the care that is the subject of the claim. If the treating Physician determines the claim is “urgent,” the Plan must treat the claim as urgent.

A “Pre-Service Claim” is a request for approval of a benefit for which the terms of the Plan condition the receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A “Post-Service Claim” is a claim that under this Plan that is not a Pre-Service Claim (i.e., a claim that involves consideration of payment or reimbursement of costs for medical care that has already been provided).

The time periods above are considered to commence when a claim is filed in accordance with the Plan’s claim filing procedures, without regard to whether all of the information necessary to decide the claim accompanies the filing.

If a claim is wholly or partially denied, the Plan will furnish the claimant a written (or electronic) notice of the denial. The written notice will be provided in a culturally and linguistically appropriate manner and will contain the following information:

- The specific reason(s) for the denial and specific reference(s) to the Plan provisions on which the denial is based. If an internal rule, guideline or other protocol was followed, then the written notice will state that such protocol was relied upon and that a copy of
such protocol is available to the claimant free of charge upon request. If the claim was
denied because it does not meet the definition of a covered health service or is
experimental in nature, or if denial is due to a similar exclusion or limit, a more
comprehensive explanation of the scientific or clinical judgment used in applying the
terms of the Plan to the claimant’s medical circumstances will be provided free of charge
to the claimant upon request;

- A description of any additional information or material necessary to perfect the claim and
an explanation of why such material or information is necessary;

- A description of the Plan’s review procedures and the time limits applicable to such
procedures, including a statement of the claimant’s right to bring a civil action under
section 502(a) of ERISA following an adverse benefit determination;

- Information sufficient to identify the claim involved, including the date of service, the
health care provider, the claim amount (if applicable), and notice of the opportunity to
request diagnosis codes and treatment codes (and their corresponding meanings);

- For a claim denial, the denial code and its corresponding meaning, as well as a
description of the Plan’s standard, if any, that was used in denying the claim;

- A description of available internal appeals and external review processes, including
information regarding how to initiate an appeal; and

- A description of the availability of, and contact information for, an applicable office of
health insurance consumer assistance or ombudsman established under Public Health
Service Act section 2793.

If the denied claim is an Urgent Care Claim, the notice will also contain a description of the
expedited review process applicable to such claims. Notification of a denied Urgent Care Claim
may be made orally, provided that (a) notification is made within the specified timeframe for
such claims, and (b) written or electronic notification is furnished to the claimant no later than 3
days after receipt of oral notification.

After receiving a written notice of claim denial, a claimant will be provided free of charge, upon
request, access to and copies of all relevant documents that were relied upon in making the
determination, or that were submitted to the Plan, or generated in the course of making the
benefit determination. The claimant will also receive any information demonstrating that, in
making the adverse claim determination, the Plan complied with its own processes for ensuring
appropriate decision-making and consistency. A document, record or other information is
considered relevant if it constitutes a statement of policy or guidance with respect to the Plan
concerning the denied treatment option or benefit for that claimant’s diagnosis, without regard to
whether such advice or statement was relied upon in making the determination.

**CONCURRENT CARE DECISIONS**

Any decision by the Plan to terminate or reduce benefits that have already been granted with the
potential of causing disruption to ongoing care, course of treatment, number of treatments or
treatments provided that meet the definition of a covered health service shall be considered a benefit denial and shall be subject to the Urgent Care Claim timeframe as outlined above.

Any Urgent Care Claim requesting to extend a course of treatment beyond the initially prescribed period of time or number of treatments must be decided within 24 hours, provided that the claim is made at least 24 hours prior to the expiration of the initially prescribed period.

**INCOMPLETE CLAIMS NOTIFICATION**

In the event additional information is required to make a claim determination, the Plan will provide the claimant notification which will include a description of the specific information needed to complete the claim. In the case of Urgent Care Claims, this notice must be provided within 24 hours after receipt of the claim. The claimant shall be afforded at least 48 hours from receipt of the notice in which to provide the specified information. The Plan shall make its initial determination as soon as possible, but in no case later than 48 hours after the earlier of (a) the Plan’s receipt of the specified information, or (b) the end of the period afforded the claimant to provide the specified additional information.

In the case of Pre-Service Claims and Post-Service Claims, a notice specifying the additional information needed to complete the claim must be provided as soon as reasonably possible within the relevant initial claim determination timeframe. The claimant shall be afforded at least 45 days after receipt of the notice in which to provide the specified information. The Plan may require an extension of time as described below in order to make an initial determination.

**EXTENSIONS OF TIME**

The Plan may extend decision-making on both Pre-Service Claims and Post-Service claims for one additional period of 15 days after expiration of the relevant initial period, if the Plan Administrator determines that such an extension is necessary for reasons beyond the control of the Plan, provided that the Plan notifies the claimant, prior to the expiration of the relevant initial period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. There is no extension permitted in the case of Urgent Care Claims.

If the reason for taking the extension is the failure of a claimant to provide necessary information, the time period for making the determination is tolled, from the date on which notice of the necessary information is provided to the claimant, until the date on which the claimant responds to the notice. This tolling period ends on the date on which the Plan receives the claimant’s response to the notice. Once the claimant responds, the Plan may take an extension of time (15 calendar days for Pre-Service and Post-Service Claims) within which to make an initial determination. The Plan may take only one extension for a group health claim and may not further extend the time for making its decision unless the claimant agrees to a further extension.

**FAILURE TO FOLLOW CLAIM FILING PROCEDURES**

In the event a claimant does not follow the Plan’s claim filing procedures, the Plan will notify the claimant accordingly. In the case of Urgent Care Claims, the Plan must notify the claimant of failure to follow filing procedures within 24 hours. In the case of Pre-Service Claims, the Plan
must notify the claimant of a failure to follow filing procedures within 5 calendar days. Notification by the Plan will be oral, unless written notification is requested by the claimant or authorized representative. The notification timeframe for Pre-Service Claims will apply only when a communication is received from a claimant or health care professional representing the claimant that specifies the identity of the claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested, and the communication is received by the Claims Administrator.

**APPEAL PROCESS**

In cases where a claim for benefits payment is denied in whole or in part, the claimant may appeal the denial. This appeal provision will allow the claimant to:

- Request from the Plan a review of any claim for benefits. Such request must include the name of the Employee, his or her Social Security number, the name of the patient, and the Group Identification Number, if any.
- File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Claims Administrator within 180 days after the claim payment date or the date of the notification of denial of benefits. In the case of Urgent Care Claims, a request for an expedited review may be submitted orally, and all necessary information, including the Plan’s benefit determination upon review, may be transmitted between the Plan and claimant via telephone, facsimile or other available similarly expeditious methods.

The review of the denial will be made by the Claims Administrator or by an appropriate named fiduciary who is neither the party who made the initial claim determination nor the subordinate of such party. The review will not defer to the initial claim determination and will take into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was previously submitted or relied upon in the initial determination. The names of any medical professionals consulted during the review process will be disclosed to the claimant.

The Claims Administrator will provide the claimant with a written response within:

- 72 hours after receipt of the claimant’s request for review in the case of Urgent Care Claims
- 30 calendar days after receipt of the claimant’s request for review in the case of Pre-Service Claims
- 60 calendar days after receipt of the claimant’s request for review in the case of Post-Service Claims

The Claims Administrator’s written response to the claimant will be provided in a culturally and linguistically appropriate manner and shall cite the specific Plan provision(s) upon which the denial is based and the right to bring a civil action under ERISA Section 502(a) following the
denial of your appeal. If an internal rule, guideline or other protocol was followed, then the written notice will state that such protocol was relied upon and that a copy of such protocol is available to the claimant free of charge upon request. If the claim was denied because it does not meet the definition of a covered health service or is experimental in nature, or if denial is due to a similar exclusion or limit, a more comprehensive explanation of the scientific or clinical judgment used in applying the terms of the Plan to the claimant’s medical circumstances will be provided free of charge to the claimant upon request.

The Claims Administrator’s written response will also contain the following information:

- Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and notice of the opportunity to request diagnosis codes and treatment codes (and their corresponding meanings);
- For a claim denial, the denial code and its corresponding meaning, as well as a description of the Plan’s standard, if any, that was used in denying the claim;
- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and
- A description of the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act section 2793.

The Claims Administrator’s written response shall also include a statement notifying the claimant about potential alternative dispute resolution methods, if any.

The decision of the Claims Administrator upon review is final, subject to the rights to request an external review described below.

**SPECIAL NOTE**

If federal law is amended to require shorter maximum periods for processing claims or otherwise to require changes to the claim and appeal procedures described above, those procedures will be administered in accordance with applicable federal law.
RIGHT TO EXTERNAL REVIEW

A claimant must exhaust the internal claims and appeals process described above before he or she can request an external review, except as described in the section below titled “Expedited Requests for External Review” and in the case of a “deemed exhaustion.” If the Plan fails to adhere to the internal claims and appeals process above, the claimant will be deemed to have exhausted the internal claims and appeals process and may initiate an external review as described below. Note: The internal claims and appeals process will not be “deemed exhausted” based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the Plan demonstrates that the violation was for due cause or due to matters beyond the control of the Plan, and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the claimant.

Non-Expedited Requests for External Review

If you receive notice of an adverse benefit determination upon the exhaustion or deemed exhaustion of the internal claims and appeals process described above, you (or your authorized representative) may file a written request for an external review with the Claims Administrator, provided the request filed within four months after the date of your receipt of the notice. If there is no corresponding date four months after the date of receipt of such a 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 falls 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.

External review is available only for certain claims that involve a medical judgment and for rescissions of coverage. External review is not available for any other type of claim, including claims that are denied because you fail to meet the requirements for coverage under the terms of the Plan.

Within 5 business days of the Claims Administrator’s receipt of the request for external review, a preliminary review will be conducted to determine whether the request is suitable for external review. The following determinations will be made:

- Whether you were 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;
- Whether the adverse benefit determination relates to your failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
- Whether the adverse benefit determination qualifies for external review because it involves a medical judgment or a rescission of coverage, as applicable;
- Whether you have exhausted the plan’s internal appeal process, as applicable; and
Whether you have provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, a written notification will be provided to you (or your authorized representative) as to whether the request is eligible for external review. If the request is complete but not eligible for external review, the notification will include the reason(s) for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notification will describe the information or materials needed to make the request complete. The required information must be provided no later than the last day of the four month period after the date of the denial notice (for example, not later than March 1, 2015 for a denial notice dated October 30, 2014) or 48 hours after receipt of the preliminary review notification, whichever is later.

Requests that are eligible for external review will be reviewed by an accredited independent review organization (“IRO”). The IRO will not provide any deference to any prior determination and will not be bound to any decisions or conclusions that were reached by the Claims Administrator. The assigned IRO will provide you (or your authorized representative) with a notice inviting you (or your authorized representative) to submit any additional information that you (or you authorized representative) wish the IRO to consider within 10 business days after the date of the notice. (Note: The IRO will not be required to consider any additional information that is submitted after 10 business days.) Any additional information that the IRO receives from you (or your authorized representative) will be provided to the Claims Administrator. The Claims Administrator may reconsider its prior denial on the basis of such information. If the denial is reversed and coverage or payment is provided, you (or your authorized representative) will be notified in writing and the external review will be terminated.

The IRO will review any timely received additional information you (or your representative) provides and the documents and information that the Claims Administrator reviewed in connection with its denial (for example, medical records, attending health care professional’s recommendation, the terms of the plan, appropriate practice guidelines, any applicable clinical review criteria developed and used by the Plan, the opinion of the IRO’s clinical reviewer(s), etc.). The IRO will provide you (or your authorized representative) and the Plan with its final external review decision in writing within 45 days after the IRO’s receipt of the request for external review. The IRO’s final external review decision is binding. If the IRO’s decision reverses the Claims Administrator’s adverse benefit determination or final internal adverse benefit determination, the Plan will provide the coverage or payment for the claim.

**Expedit ed Requests for External Review**

If the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, you (or your authorized representative) may file a request for an expedited external review of your claim by an IRO, provided you (or your authorized representative) file a request for an expedited internal appeal of the denied claim with the Claims Administrator at the same time.
You (or your authorized representative) may also file a request for an expedited external review by an IRO if you receive notice of an adverse benefit determination that involves a medical condition upon the exhaustion of the internal claims and appeals process described above where: (1) the timeframe for completion of a non-expedited external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or (2) the final internal adverse benefit determination concerns an admission, availability of care, continued stay or health care item or service for which you received emergency services, but have not been discharged from a facility.

The standards and processes described above regarding the preliminary review for eligibility and review by the IRO also apply to expedited requests except that the IRO will provide you (or your authorized representative) and the Plan with its final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the assigned IRO’s receipt of the request for external review. If the notice is not in writing, the IRO will provide written confirmation of its decision within 48 hours after the date it provided you (or your authorized representative) with oral notice of its decision.
COBRA CONTINUATION COVERAGE

WHAT COBRA CONTINUATION COVERAGE IS

In compliance with a federal law commonly called “COBRA,” the University offers its employees and their covered Dependents (called “Qualified Beneficiaries” by the law) the opportunity to elect a temporary continuation (called “COBRA Continuation Coverage” by the law) of the health care coverage sponsored by the University when that coverage would otherwise end because of certain events (called “Qualifying Events” by the law). Qualified Beneficiaries may elect COBRA Continuation Coverage even if they are already covered by another group health plan or by Medicare. Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

This notice is provided to you and your covered Spouse and is intended to inform both of you (and your covered Dependent Child(ren), if any), in a summary fashion, of your respective rights and obligations under the continuation coverage provisions of the law. Since this is only a summary, your actual rights will be governed by the provisions of the COBRA law itself, as in effect at the time you experience a Qualifying Event.

WHO IS ENTITLED TO COBRA CONTINUATION COVERAGE (the Qualified Beneficiary); WHY (the Qualifying Event); AND FOR HOW LONG?

A Qualified Beneficiary is entitled to elect COBRA Continuation Coverage when a Qualifying Event occurs and that person’s health care coverage ends as a result of that Qualifying Event, either as of the date of the Qualifying Event or as of some later date. The following definitions should help you understand who is entitled to COBRA Continuation Coverage, when, and for how long.

1. “Qualified Beneficiary”: Under the law, a Qualified Beneficiary is any employee, his or her Spouse or Dependent Child who was covered by this Plan on the day before a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. In addition, a child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered employee during a period of COBRA Continuation Coverage (but not someone who becomes your Spouse) is also a Qualified Beneficiary.

2. “Qualifying Event”: Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when one of the Qualifying Events occurs and causes the health care coverage of that Qualified Beneficiary to end, either at the same time the Qualifying Event occurs or at some time thereafter.

3. Maximum Period of COBRA Continuation Coverage: The maximum period of COBRA Continuation Coverage is either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the time the Qualifying Event
occurs. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances described in the provision titled Extended COBRA Continuation Coverage in Certain Cases of Disability During an 18-Month COBRA Continuation Period, that appears below. The maximum period of COBRA Continuation Coverage may be cut short for the reasons described in the provision titled When COBRA Continuation Coverage May Be Cut Short, that also appears below.

4. “Medicare Entitlement”: A person becomes entitled to Medicare on the first of the month in which he or she attains age 65, but only if he or she submits the required application for Social Security retirement benefits within the time period prescribed by law. A person may also become entitled to Medicare on the first day of the 30th month after the date on which he or she was determined by the Social Security Administration to be totally and permanently disabled so as to be entitled to Social Security disability income benefits.

The following chart lists all Qualifying Events, identifies each person who may be a Qualified Beneficiary, and indicates the maximum period of COBRA Continuation Coverage based on that Qualifying Event.

<table>
<thead>
<tr>
<th>Qualifying Event Causing Coverage to End</th>
<th>Qualified Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Employee</td>
</tr>
<tr>
<td>Employee is terminated (for other than gross misconduct)</td>
<td>18 months</td>
</tr>
<tr>
<td>Employee has a reduction in hours worked (making the employee ineligible for the same coverage under the terms of the Plan)</td>
<td>18 months</td>
</tr>
<tr>
<td>Employee dies</td>
<td>N/A</td>
</tr>
<tr>
<td>Employee becomes divorced or legally separated</td>
<td>N/A</td>
</tr>
<tr>
<td>Employee becomes entitled to Medicare</td>
<td>N/A</td>
</tr>
<tr>
<td>Dependent Child ceases to have Dependent status</td>
<td>N/A</td>
</tr>
</tbody>
</table>
WHEN THE PLAN MUST BE NOTIFIED OF A QUALIFYING EVENT

(Very Important Information)

In order to have the chance to elect COBRA Continuation Coverage after a divorce or legal separation, your entitlement to Medicare, or a child is ceasing to be a Dependent Child under the Plan, you and/or a family member MUST INFORM THE PLAN IN WRITING OF THAT EVENT NO LATER THAN 60 DAYS AFTER THAT EVENT OCCURS. The written notice must describe the particular Qualifying Event triggering the COBRA coverage (e.g., identify whether the qualifying event was due to divorce, legal separation, or loss of dependent child status) and the date on which the event occurred. That notice should be sent to the University, Director of Employee Benefits at:

Director of Employee Benefits
St. John’s University
8000 Utopia Parkway
Jamaica, New York 11439
Telephone: 718-990-6587

The University will contact P&A Group and request that a COBRA notice be sent to you.

IF SUCH A NOTICE IS NOT RECEIVED BY THE UNIVERSITY WITHIN THAT 60-DAY PERIOD, THE DEPENDENT WILL NOT BE ENTITLED TO ELECT COBRA CONTINUATION COVERAGE.

NOTICE YOU WILL RECEIVE WHEN ENTITLED TO COBRA COVERAGE

When your employment terminates or your hours are reduced so that you are no longer entitled to coverage under the Plan, or when the University is notified on a timely basis that you died, divorced or were legally separated, became entitled to Medicare, or that a Dependent Child lost Dependent status, the Director of Employee Benefits will give you and/or your covered Dependents notice of the date on which your or their coverage ends, together with the information and forms you or they will need to elect COBRA Continuation Coverage. Under the law, you and/or your covered Dependents will then have only 60 days to elect COBRA Continuation Coverage measured from the later of (i) the date notice is received, and (ii) the Qualifying Event.

IF YOU AND/OR ANY OF YOUR COVERED DEPENDENTS DO NOT ELECT COBRA CONTINUATION COVERAGE WITHIN THAT 60-DAY PERIOD, YOU AND/OR THEY WILL NOT HAVE ANY GROUP HEALTH COVERAGE FROM THIS PLAN.

COBRA CONTINUATION COVERAGE THAT WILL BE PROVIDED

If you or your covered Dependent(s) elect COBRA Continuation Coverage, you or they will be entitled to the same health care coverage that you or they had when the Qualifying Event occurred that caused your or their health care coverage under the Plan to end, but you or they must pay for
it. See the provision titled *Paying for COBRA Continuation Coverage* that appears immediately below for information about how much COBRA Continuation Coverage will cost you or them and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will be made in your or their COBRA Continuation Coverage.

**PAYING FOR COBRA CONTINUATION COVERAGE**

**A. How Much COBRA Continuation Coverage Will Cost You**

By law, any person who elects COBRA Continuation Coverage will have to pay the full cost of the COBRA Continuation Coverage. The University is permitted to charge the full cost of coverage for similarly situated active employees and families (including both the University’s and the employee’s share) plus (1) an additional 2%; or (2) an additional 50% if (a) the 18-month period of COBRA Continuation Coverage is extended because of disability as described below in the section titled “Extended COBRA Continuation Coverage in Certain Cases of Disability During an 18-Month COBRA Continuation Period” below, and (b) the disabled person is covered during the 11-month period following the 18th month of COBRA Continuation Coverage.

Each person will be told the exact cost of COBRA Continuation Coverage that applies when he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be increased during the period it remains in effect.

**B. Grace Periods**

The initial payment for the COBRA Continuation Coverage is due 45 days after COBRA Continuation Coverage is actually elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After that, payments are due on the first day of each month, but you will have a 31-day grace period to make those payments. If payments are not made within the times indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the date the payment became due.

**C. Confirmation of Coverage Before the COBRA Cost Is Paid**

If, during the 45-day grace period for the initial payment and/or any subsequent 31-day grace period for regular monthly payments:

- you, your Spouse or Dependent Child(ren) have elected COBRA Continuation Coverage;
- the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect; and
- a Health Care Provider requests confirmation of coverage.

COBRA Continuation Coverage will be confirmed, but with notice to the Health Care Provider that:
the cost of the COBRA Continuation Coverage has not been paid;
claims will not be paid unless and until the amounts due have been received; and
the COBRA Continuation Coverage will terminate effective as of the due date of any
unpaid amount if payment of the amount due is not received by the end of the grace
period.

EXTENDED COBRA CONTINUATION COVERAGE

A. When a Second Qualifying Event Occurs During an 18-Month COBRA
   Continuation Period

   • If, during the 18-month period of COBRA Continuation Coverage resulting from loss
     of coverage because of your termination of employment or reduction in hours, you die,
     become divorced or legally separated, or become entitled to Medicare, or if a covered
     child ceases to be a Dependent Child under the Plan, the maximum COBRA
     continuation period for the affected spouse and/or child is extended to 36 months
     measured from the date of your termination of employment or reduction in hours (or
     the date you first became entitled to Medicare, if that is earlier, as described in the next
     subparagraph).

   • If you become entitled to COBRA Continuation Coverage because of termination of
     employment or reduction in hours worked that occurred less than 18 months after the
     date you become entitled to Medicare, and if your Spouse and/or any Dependent Child
     has a second Qualifying Event as described in the first subparagraph above, your
     Spouse and/or Dependent Child would be entitled to a 36-month period of COBRA
     Continuation Coverage measured from the date you became entitled to Medicare rather
     than from the date of your termination of employment or reduction in hours worked.

   • This extended period of COBRA Continuation Coverage is not available to anyone
     who became your spouse after the termination of employment or reduction in hours.  However,
     this extended period of COBRA Continuation Coverage is available to any
     child(ren) born to, adopted by or placed for adoption with you during the 18-month
     period of COBRA Continuation Coverage.

   • In no case is any employee whose employment terminated or who had a reduction in
     hours entitled to COBRA Continuation Coverage for more than a total of 18 months
     (unless that employee is entitled to an additional period of up to 11 months of COBRA
     Continuation Coverage on account of disability as described in the in the section titled
     “Extended COBRA Continuation Coverage in Certain Cases of Disability During an
     18-Month COBRA Continuation Period” below).  As a result, if during an 18-month
     COBRA Continuation period following a reduction in hours, your employment is
     terminated, that termination of employment will not be treated as a new separate
     Qualifying Event.
• In no event will your Spouse or Dependent Child(ren) be entitled to COBRA Continuation Coverage, through an extension of the COBRA continuation period or otherwise, for more than a total of 36 months.

B. Extended COBRA Continuation Coverage in Certain Cases of Disability During an 18-Month COBRA Continuation Period

• If, at any time during or before the first 60 days of an 18-month period of COBRA Continuation Coverage, you or your covered Spouse or Dependent Child became disabled, and as a result of that disability the Social Security Administration makes a formal determination that you or that covered Spouse or Dependent Child is entitled to Social Security disability income benefits, the disabled person, and/or any covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare (whichever is sooner).

• This extension is available only if:
  • the Social Security Administration determines that the individual’s disability began no later than 60 days after the termination of employment or reduction in hours;
  • you or another family member notifies the University of the Social Security Administration’s determination within 60 days after that determination was received by you or another covered family member; and
  • that notice is received by the University before the end of the 18-month COBRA continuation period.

NOTICE OF UNAVAILABILITY OF CONTINUATION COVERAGE

If the Plan Administrator is notified of a Qualifying Event, a second Qualifying Event, or a determination of disability by the Social Security Administration, regarding a Qualified Beneficiary, and if the Plan Administrator determines that such individual is not entitled to the COBRA Continuation Coverage being requested, the Plan Administrator will notify the individual of that fact within 14 days of the receipt of such request.

ADDITION OF NEWLY ACQUIRED DEPENDENTS

If, while you are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that spouse or child for Dependent coverage for the balance of the period of COBRA Continuation Coverage by doing so within 31 days after the marriage, birth, adoption, or placement for adoption. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

WHEN COBRA CONTINUATION COVERAGE MAY BE CUT SHORT

Once COBRA Continuation Coverage has been elected, it may be cut short as of the date on which any of the following events occur:
1. The University no longer provides group health coverage to any of its employees;

2. The amount due for the COBRA Continuation Coverage is not paid on time;

3. You or one of your Covered Dependents becomes entitled to Medicare (not merely eligible for Medicare);

4. You and/or one of your Covered Dependents becomes covered under another group health plan (not merely eligible for coverage) and that plan does not contain any legally applicable exclusion or limitation with respect to that person’s pre-existing condition;

5. The coverage may be terminated for cause under the terms of the Plan that apply to similarly situated non-COBRA beneficiaries (for example, submission of a fraudulent claim); or

6. If the disability extension applies, there is a final determination that the Qualified Beneficiary is no longer disabled under the Social Security Act. The University must be notified, in writing, within 30 days of the date of any final determination that the disability has ended. Extended health coverage will be terminated in the month that begins more than 30 days after the date of the final determination that the Qualified Beneficiary is no longer disabled.

In the event that a Qualified Beneficiary’s COBRA Continuation Coverage is terminated prior to the end of the maximum period of continuation coverage applicable under COBRA, the Plan Administrator will notify the Qualified Beneficiary of the loss of COBRA Continuation Coverage as soon as practicable following such determination.

ENTITLEMENT TO CONVERT TO AN INDIVIDUAL HEALTH PLAN

At the end of the 18-month or 36-month period of COBRA Continuation Coverage, you will be allowed to enroll in an individual conversion health plan as provided by the Plan, if that right is offered by the Plan at the time the maximum period of COBRA Continuation Coverage expires. At the present time, conversion rights are available under the Plan’s Medical Program. When the maximum period of COBRA Continuation Coverage expires, you and/or your Dependents who are then covered will be advised of the conversion rights that are available to them.
WHOM TO CONTACT IF YOU HAVE QUESTIONS OR TO GIVE NOTICE OF CHANGES IN YOUR CIRCUMSTANCES

(Very Important Information)

1. If you have any questions about your COBRA rights, please contact:

   Director of Employee Benefits
   St. John’s University
   8000 Utopia Parkway
   Jamaica, New York 11439
   Telephone: 718-990-6587

2. Also, remember that to avoid loss of any of your rights to obtain COBRA Continuation Coverage, YOU MUST NOTIFY THE UNIVERSITY PROMPTLY (WITHIN 60 DAYS) AND IN WRITING if:

   • you have any change of marital status;
   • you have a new Dependent Child;
   • you or a covered Spouse or Dependent Child has been determined to be totally and permanently disabled by the Social Security Administration and if the Social Security Administration determines that the disability has been terminated;
   • a covered child ceases to be a Dependent Child as defined by the Plan; or
   • you or your Spouse has a change of address.
OTHER INFORMATION

NAME OF THE PLAN

St. John’s University Point-of-Service Plan

NAME AND ADDRESS OF EMPLOYER MAINTAINING THE PLAN

For St. John’s University, its subsidiaries, and the subsidiaries of its subsidiaries, the Plan is sponsored by:

St. John’s University
8000 Utopia Parkway
Jamaica, New York 11439
Telephone: 718-990-6587

EMPLOYER IDENTIFICATION NUMBER

11-1630830

PLAN NUMBER

502

TYPE OF PLAN

The Plan is a welfare benefit plan, as defined under ERISA, providing medical benefits.

TYPE OF ADMINISTRATION

The Point-of-Service plan is self-funded and administered by Oxford Health Plans, New York, New York.

PLAN ADMINISTRATOR

Attn.: Director of Employee Benefits
St. John’s University
8000 Utopia Parkway
Jamaica, New York 11439
Telephone: 718-990-6587

CLAIMS REVIEW FIDUCIARY

Oxford Health Plans, New York, New York is the named claim review Fiduciary to provide a full and fair review of denied claims for this plan.
AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made on the Plan Administrator or on:

General Counsel
St. John’s University
8000 Utopia Parkway
Jamaica, New York 11439

PLAN YEAR

The Plan Year is the calendar year. The Plan’s records are kept on a Plan Year basis.

WOMEN’S HEALTH AND CANCER RIGHTS NOTICE

As required by the Women’s Health and Cancer Rights Act of 1998, the Plan covers the following breast reconstruction procedures in connection with mastectomies:

- reconstruction of the breast that was operated on;
- surgery on and reconstruction of the other breast to produce symmetrical appearance; and
- treatment of physical complications, including lymph edemas, at all stages of the mastectomy.

Benefits are also provided for an external breast prosthesis following the mastectomy when prescribed by a physician and furnished by an accredited supplier. Coverage includes two post-surgical forms and two surgical bras. Replacements are also covered when required as a result of a significant change in body weight which renders the prosthesis unusable.

MATERNITY LENGTH OF HOSPITAL STAY NOTICE

In accordance with federal law, the University’s medical plan provides specific minimum benefit for any length of hospital stay in connection with childbirth. Following a normal vaginal delivery the minimum hospital length of stay for the mother and newborn child is 48 hours. For a cesarean section, the minimum length of hospital stay for the mother and newborn is 96 hours following delivery. Also, a doctor or hospital is not required to obtain authorization for a delivery-related hospital stay that are within these minimum time periods. If the mother, her attending physician and the hospital agree that a shorter length of stay is sufficient, the mother and the newborn child may leave the hospital before the minimum 48- or 96-hour stay proscribed by federal law.
STATEMENT OF ERISA RIGHTS

As a participant in the St. John’s University Point-of-Service 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:

1. Receive Information About Your Plan and Benefits

   - Examine, without charge, at the University’s Employee Benefits Office at 8000 Utopia Parkway, Jamaica, NY, all documents governing the Plan, including any insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

   - Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including any insurance contracts and collective bargaining agreements, and a copy of the latest annual report (IRS Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

   - Receive a summary of the Plan’s annual financial report as required by law.

2. Continue Your Group Health Plan Coverage

Continue health care coverage for yourself, and/or your covered Spouse or Dependent Child(ren) (if any) if there is a loss of coverage under the Plan as a result of a Qualifying Event pursuant to the rules set forth in the chapter of this SPD titled COBRA Continuation Coverage. You and/or your Dependents may have to pay for such coverage if it is elected.

3. Certificate of Creditable Coverage

Receive a Certificate of Creditable Coverage, free of charge, shortly after your coverage under this Plan ends for any reason prior to December 31, 2014. If you become entitled to COBRA Continuation Coverage prior to December 31, 2014, that Certificate will be provided to you, free of charge, on or about the time that your notice of entitlement to COBRA Continuation Coverage is given to you. If you elect COBRA Continuation Coverage prior to December 31, 2014, a new Certificate will be provided to you again, free of charge, when your COBRA Continuation Coverage ends for any reason.

Prior to December 31, 2014, a new Certificate will also be made available to you, free of charge, whenever you request it at any time for up to 24 months after your coverage ends for any reason. Without evidence of Creditable Coverage you may be subject to an exclusion of coverage for expenses arising on account of any pre-
existing condition for 12 months (18 months for late enrollees) after your enrollment date in any new medical coverage you may obtain thereafter. (Note: Pre-existing condition exclusions will be prohibited by federal law beginning in 2014, although certain plans may not be subject to this requirement until mid-year in 2014.)

As of December 31, 2014, the Plan will no longer provide Certificates of Creditable Coverage because of changes to federal law.

4. **Prudent Actions 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 employee benefit 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 beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

5. **Enforce Your Rights**

- If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report 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. However, contact Oxford Health Plans (N.Y.), Inc. for an explanation of the claims review procedure that must be followed before you may file a suit. If you are dissatisfied with any determination under the review procedure applicable to the Oxford Health Plan, see the provisions regarding appeal of review determinations in the Oxford booklet of this SPD.

- In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.
If it should happen that the 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 the court finds your claim is frivolous).

6. 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, or if you need assistance in obtaining documents from the Plan Administrator, 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.
PLAN AMENDMENTS OR TERMINATION OF PLAN

The University reserves the right to amend or terminate this Plan, or any part of it at any time. Amendments may be made in writing by the Director of Employee Benefits and will become effective on the date specified in the document amending the Plan. The Plan may be terminated by written document by the President of the University, and new programs may be added to the Plan by written document by the Director of Employee Benefits.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

In carrying out their respective responsibilities under the Plan, the Plan Administrator, and other Plan Fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, including but not limited to Oxford Health Plans, have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF THE UNIVERSITY’S RIGHTS

A. The University makes no representation that employment with it represents lifetime security or a guarantee of continued employment. Subject to the terms of any applicable collective bargaining agreement, your employment may be terminated for any reason or for no reason.

B. Your employment may also be terminated whenever the University, in its sole judgment, deems your termination of employment to be in the University’s best interest.

C. The University, as Plan Sponsor, intends that the terms of this Plan described in this SPD, including those relating to coverage and benefits, are legally enforceable, and that the Plan is maintained for the exclusive benefit of participants, as defined by law.

D. Any written or oral statement, other than an official summary of material modification of the Plan or written statement signed by the Director of Employee Benefits or the President of the University that is contrary to the provisions of this SPD, is invalid, and no prospective, active or former employee may rely on any such statement.

NO CONTRACT OF EMPLOYMENT

Neither the University’s offer of this Plan to its employees nor the acceptance of coverage under this Plan by you or any other employee shall constitute a contract of employment.

NO LIABILITY FOR PRACTICE OF MEDICINE
The Plan, Plan Administrator or any of their designees, including but not limited to Oxford Health Plans, are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the Plan, Plan Administrator, nor any of their designees, including but not limited to Oxford Health Plans, will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

**PRIVACY, CONFIDENTIALITY, RELEASE OF RECORDS OR INFORMATION**

Any health care information collected by the Plan will be treated as confidential information, and will not be disclosed to anyone without your written consent, except as follows:

1. Information will be disclosed to those who require that information to administer the Plan, to process claims, or as permitted by applicable law.

2. Information with respect to duplicate coverage will be disclosed to the Plan or insurer that provides duplicate coverage.

3. Information needed to determine if health care services or supplies are medically necessary, experimental and/or investigational, or if the charges for them are usual (or reasonable) and customary, will be disclosed to the individual or entity consulted to assist Oxford Health Plans (N.Y.), Inc. or its designee to make those determinations.

4. Information will be disclosed as required by law or regulation or in response to a duly issued subpoena.

In addition, the Plan will comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), as follows:

A. **HIPAA Non-Discrimination Rules:** This Plan will not deny group health benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or medical condition (including both physical and mental health conditions). For example, the group health benefits will not exclude coverage for self-inflicted injuries due to a suicide attempt by a person who suffers from depression.

B. **HIPAA Privacy and Security Rules:** This Plan will protect individually identifiable health information as required by the “Administrative Simplification” provisions of the HIPAA regulations.

See the chapters listed in the chart titled Program Provided by the Plan in the Introduction chapter of this SPD, or the then-current updated chart for Plan Years after 2001, for any additional
information regarding privacy, confidentiality or release of records or information related to these Programs.

INFORMATION YOU OR YOUR DEPENDENTS MUST FURNISH TO THE PLAN

(Very Important Information)

In addition to information you must furnish in support of any claim for Plan benefits under this Plan, you or your covered Dependents must furnish, in writing, within 60 days after the event, any information you or they may have that may affect eligibility for coverage under the Plan. If you fail to do so, you or your covered Dependents may lose the right to obtain COBRA Continuation Coverage or to continue coverage of a Dependent Child who has a physical or mental Handicap. This includes, but is not limited to:

1. Change of name.

2. Change of address.

3. Marriage, divorce or legal separation, or death of you or any covered Spouse or Dependent Child.

4. Any information regarding a change of status of a Dependent Child, including, but not limited to:
   - The Dependent Child reaching the Plan’s limiting age;
   - Change in the school status of a Dependent Child over age 25, including:
     - Start of a full-time college or vocational school program;
     - Termination of full-time college or vocational school program for any reason;
   - Marriage;
   - Start of military or any similar service;
   - Start of any full-time employment;
   - The existence of any physical or mental Handicap; or
   - The termination of any physical or mental Handicap.

5. Medicare enrollment or disenrollment.

6. The existence of other medical coverage.

Notices of the foregoing information should be sent, in writing, to:

Director of Employee Benefits
St. John’s University
8000 Utopia Parkway
Jamaica, New York 11439
Telephone: 718-990-6587

#1389234
SEVERABILITY OF PLAN PROVISIONS

If any provision of this Plan is determined to be invalid, that determination shall not affect the validity of any other Plan provision.

HEADINGS DO NOT MODIFY PLAN PROVISIONS

The headings of the chapters, subchapters, sections, paragraphs and subparagraphs are included for the sole purpose of generally identifying the subject matter of the substantive text so that a table of contents and index can be constructed for your convenience. These headings are not part of the substantive text of any provision, and they should not be construed to modify the text of any substantive provision in any way. Likewise, the use of bold text for emphasis in various provisions should not be construed to imply that provisions that are not in bold text are not important.

ADMINISTRATIVE PROVISIONS

A. Appointment of Plan Administrator

The Plan Administrator is the University’s Director of Employee Benefits.

B. Plan Administrator’s Responsibilities

The Plan Administrator (or its designee) shall have the authority and responsibility, among other things, for the items listed below:

1. establishing the policies, practices and procedures of this Plan;
2. hiring all persons providing services to the Plan;
3. acting as this Plan’s agent for the service of legal process;
4. complying with ERISA’s reporting and disclosure requirements; and
5. receiving all disclosures required of fiduciaries and other service providers under ERISA or any other federal or state law.

C. Action By the University

Any authority or responsibility allocated or reserved to the University under this Plan may be exercised by any duly authorized officer of the University (or his or her duly authorized designee).

D. Expenses
To the extent approved by the University, all expenses of administration may be paid by the Plan. Such expenses may include any expenses incident to the performance of a fiduciary’s responsibilities, including, but not limited to, claims administration fees and costs, fees for accountants, legal counsel and other specialists, bonding expenses, and other costs of administering this Plan. Until paid, such approved expenses shall constitute a liability of the Plan. However, the University may pay directly, or may reimburse the Plan, for any administration expense incurred.

E. Bonding

Every fiduciary and other person who handles funds or other property of this Plan shall be bonded to the extent required by Section 412 of ERISA.

F. Named Fiduciaries

The named fiduciary of this Plan shall be the Plan Administrator. The Plan Administrator may designate other named fiduciaries to have complete authority to determine whether and to what extent participants and beneficiaries are entitled to benefits under the Plan and to review all denied claims for benefits under the Plan. To the extent any insurance company or health maintenance organization exercises discretionary authority or discretionary responsibility over the benefit claims procedure set forth in the Plan, it shall be a fiduciary for purposes of the Plan and shall have the authority and discretion to construe any uncertain or disputed term or provision in its contracts, booklets and certificates.

G. University’s Responsibilities

The University (or its designee) shall have the authority and responsibility for, among other things, the following:

1. designing the Plan, including the right to amend or terminate the Plan; and
2. collecting contributions, if any, by employees.

H. Re-allocation of Responsibilities

The named fiduciaries may re-allocate their responsibilities among themselves pursuant to an instrument executed by all of the named fiduciaries.

I. Delegation of Responsibilities

Each named fiduciary may delegate its responsibilities to persons other than named fiduciaries. Such delegation shall be permissible only if the proposed delegate executes an instrument acknowledging acceptance of such delegation on the instrument. Notice of the delegation shall be communicated by the University to each other named fiduciary or
delegate. A named fiduciary may delegate its responsibilities to its employees without the restrictions of this Section.

J. Advisors to Plan Administrator

The Plan Administrator may employ actuaries, attorneys, accountants, brokers, employee benefit consultants, and other specialists to render advice concerning any responsibility it has under this Plan.

K. Notice of Appointments or Delegations

No named fiduciary shall recognize or take notice of the appointment of another named fiduciary, unless and until the University notifies the named fiduciary in writing of such appointment or delegation. The named fiduciaries may assume that an appointment or delegation continues in effect until the named fiduciary receives written notice to the contrary from the University.

L. Written Directions

Whenever a named fiduciary or delegate must or may act upon the written direction of another named fiduciary or delegate, the named fiduciary or delegate is not required to inquire into the propriety of such direction and shall follow the direction unless it is clear on its face that the actions to be taken under the direction would be prohibited by ERISA or the terms of this Plan. Moreover, the named fiduciary or delegate shall not be responsible for failure to act without such written directions.

M. Limitation of Responsibilities

None of the fiduciary responsibilities allocated or delegated under the Plan shall be shared by two or more fiduciaries, unless such sharing is mandated by this Plan or related instruments. Wherever one fiduciary is required by this Plan to follow the directions of another fiduciary, the two fiduciaries shall not be deemed to have been assigned a shared responsibility, but the responsibility of one fiduciary shall be to give the directions, and the responsibility of the other fiduciary shall be to follow them.

N. Indemnity by the University

In the event and to the extent not insured against by any insurance company pursuant to provisions of an applicable insurance policy, the University shall indemnify and hold harmless the Plan Administrator from any and all claims, demands, suits or proceedings in connection with the Plan that may be brought by the participants or their beneficiaries or legal representatives, or by any other person, corporation, entity, government or agency thereof; provided, however, that such indemnification shall not apply to any such person for such person’s acts of willful or grossly negligent misconduct in connection with the Plan, or for breaches of such person’s fiduciary obligations or duties, as described under ERISA.
MISCELLANEOUS PROVISIONS

A. No Pre-existing Condition Exclusions

As of January 1, 2014, the Plan does not impose any pre-existing condition exclusions (as defined in 45 C.F.R. § 144.103).

B. Rescission of Coverage Restrictions

Under certain circumstances prescribed by the Patient Protection and Affordable Care Act, the Plan does not rescind coverage with retroactive effect unless the individual covered under the Plan performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan. The Plan will provide at least 30 days advance written notice to each individual who would be affected before coverage is rescinded. A cancellation or discontinuance of coverage with retroactive effective is permitted (and is not considered a rescission) to the extent it is attributable to an Eligible Employee’s failure to timely pay required premiums or contributions towards the cost of coverage under the Plan.

C. No Lifetime or Annual Limits on the Dollar Amount of Essential Health Benefits

The Plan does not impose any lifetime limits on the dollar value of essential health benefits (as defined in Section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations) for any individual.

D. Medicaid Benefits

Payment for health benefits with respect to a participant under the Plan will be made in accordance with any assignment of rights made by or on behalf of such participant (or a beneficiary of the participant) as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

E. States Rights

To the extent that payment has been made under a State plan for medical assistance approved under Title XIX of the Social Security Act in any case in which the Plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under the Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a participant to such payment for such items or services.

F. Retroactive Amendments
An amendment to this Plan may be made effective retroactively so long as it does not adversely affect the right of participants to benefits under this Plan for claims incurred after the effective date of the amendment, but before the amendment is adopted.

G.  Right to Terminate

In recognition of the fact that future conditions and circumstances cannot now be entirely foreseen, the University expressly reserves the unqualified right to terminate the Plan or any benefits under the Plan at any time and for any reason.

H.  No Contractual or Vesting Right to Benefits

Notwithstanding any other provision in the Plan to the contrary, a participant, dependent and/or other claimant shall not have any right to benefits under the Plan which in any way interferes with the University’s right to amend or terminate the Plan. This Plan is not a contract. THE UNIVERSITY MAKES NO PROMISE TO CONTINUE PLAN BENEFITS IN THE FUTURE, AND RIGHTS TO FUTURE BENEFITS WILL NEVER VEST. In particular, retirement does not in any manner confer upon any participant, dependent, or other interested party any right to continued benefits under this Plan or any other welfare benefit plan maintained by the University. Nothing in this Section shall be construed as interfering with an individual’s continuation rights as described in the Plan.

I.  Governing Law

The Plan is established under, and shall be governed and construed according to, the laws of the State of New York, to the extent such laws are not preempted by ERISA.

J.  Jurisdiction and Venue

The jurisdiction of any proceeding arising out of or with respect to the Plan or Plan benefits shall be in a court of competent jurisdiction in New York State. The parties to any such proceeding shall be subject to personal jurisdiction in New York State. Venue of any proceeding shall lie in Queens County, New York, if a state court action, and in the United States District Court, Eastern District of New York, if a federal court action.

K.  Invalidity

The invalidity or unenforceability of any term or provision of this Plan shall not affect the other terms and provisions, and such invalid or unenforceable term or provision shall, in all events, be construed and enforced to the fullest extent permissible under law.

L.  Gender and Number

Wherever any words are used herein in the masculine, feminine or neuter, they shall be construed as though they were also used in another gender in all cases where they would
so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

M. Protective Clause

The University shall not be responsible for the validity of any insurance company, HMO or third party administrator document issued in connection with the Plan or for the failure on the part of an insurance company, HMO, or third party administrator to make payments provided by such documents, or for the action of any person which may delay such payment(s) or render such document(s) null and void or unenforceable in whole or in part.

N. Severability of Plan Provisions

If any provision of this Plan is determined to be invalid, that determination shall not affect the validity of any other Plan provision.
HIPAA PRIVACY

Preamble. This Article is to allow the St. John’s University Point-of-Service Plan (the “Plan”) to disclose Protected Health Information to St. John’s University (“Employer”) in certain situations as permitted by HIPAA. References in this Article to disclosures from the Plan made to the Employer include disclosures to employees of the Employer, as described below.

Disclosures of Summary Health Information. The Plan may disclose Summary Health Information to the Employer if the Employer requests this information in order to obtain premium bids for health insurance coverage under the Plan, or in order to modify, amend or terminate the Plan.

Enrollment and Disenrollment Information. The Plan may disclose information to the Employer concerning whether or not an Individual is participating in the Plan.

Disclosures Pursuant to an Authorization. The Plan may disclose Protected Health Information to the Employer if the disclosure is made pursuant to a valid Authorization and the information is used as described in the Authorization. In particular, the Plan may disclose Protected Health Information to the Employer pursuant to an Authorization to assist employees and their beneficiaries in connection with their claims under the Plan, or to help them understand the terms of the Plan as they may relate to a particular condition or claim.

Disclosures for Administration Purposes. The Plan may disclose Protected Health Information to the Employer so it can carry out its Administration functions under the Plan. These functions include Payment and Health Care Operations, including without limitation, quality assurance, claims processing, processing and deciding appeals, claims auditing, claims monitoring, monitoring and managing carve-out plans such as vision and dental coverages, procuring stop-loss coverage, and reminding participants and beneficiaries of appointments or advising them of potential alternative treatments or services. For purposes of this Section, Administration functions do not include any of the matters described above, do not include any employment-related functions or functions in connection with any other benefit or benefit plans of the Employer, and do not include any disclosures which otherwise conflict with the Privacy Rules. Disclosures of Protected Health Information for Plan Administration purposes may only be made if the conditions described below are met.

The Employer must agree and comply with the following requirements before the Plan may disclose Protected Health Information to the Employer for Plan Administration purposes:

(i) The use or disclosure must be described in the Plan’s Notice of Privacy Practices issued pursuant to 45 CFR 164.520;

(ii) The Employer must certify that the Plan documents have been amended as required by 45 CFR 164.504, and that it agrees to adhere to the requirements of this Article;

(iii) The Employer may not use or further disclose Protected Health Information provided to it except as permitted by the Plan documents (as amended to comply with HIPAA), or as required by law;
(iv) The Employer will insure that any agents or subcontractors to whom it provides Protected Health Information received from the Plan will agree to the same restrictions and conditions on the use and disclosure of this information that apply to the Employer;

(v) The Employer will not use or disclose Protected Health Information received from the Plan for any employment-related actions or decisions, or in connection with any other benefit or benefit plan it maintains;

(vi) The Employer will report to the Plan any use or disclosure of PHI which it has received from the Plan and which is inconsistent with allowed uses and disclosures, to the extent it becomes aware of such uses and disclosures;

(vii) The Employer will make the Protected Health Information it receives from the Plan available to Individuals as required by 45 CFR 164.524 (pertaining to inspection and copying); 45 CFR 164.526 (pertaining to amendment); and 45 CFR 164.528 (pertaining to accounting);

(viii) The Employer will make its internal practices, books and records relating to the use and disclosure of PHI it receives from the Plan available to the Secretary of Health and Human Services or his or her designee, to determine the Plan’s compliance with the Privacy Rules;

(ix) The Employer will, if feasible, return or destroy all Protected Health Information received from the Plan in any form, and retain no copies, when the information is no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, the Employer will limit further uses and disclosures of the Protected Health Information to those purposes which make the return or destruction infeasible.

The Employer must provide for adequate separation between itself and the Plan. Access to Protected Health Information shall only be to certain, designated employees and such person(s) will receive only the minimum Protected Health Information necessary to accomplish the Administrative functions which he or she performs for the Plan. If this person(s) or other employees of the Employer do not comply with the requirements of the Plan in respect to the use and disclosure of Protected Health Information, the Employer will impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. These sanctions will be imposed in accordance with the Employer’s normal disciplinary policies, and can include termination of employment.

No Other Disclosures of Protected Health Information. The Plan will not disclose Protected Health Information to the Employer (and will not cause a Health Insurance Issuer or HMO to disclose Protected Health Information to the Employer) except as described in this Section.

Definitions.

Authorization. A document signed by an Individual authorizing disclosure of Protected Health Information and complying with the requirements of 45 CFR 164.508.
Health Care Operations. “Health Care Operations” mean any of the following activities of the Plan:

(i) conducting quality assessment and improvement activities, including outcomes evaluations and development of clinical guidelines specific to the Plan;

(ii) population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination, contacting Health Care Providers and patients with information about treatment alternatives, and related functions which do not involve Treatment;

(iii) reviewing the competence or qualification of health care professionals, evaluating practitioner or provider performance, training of students or practitioners in which the students or practitioners learn under supervision to practice or improve their professional skills, training non-health care professionals, and accreditation, certification, licensing or credentialing activities;

(iv) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a health insurance contract or health benefits, as well as ceding, securing or placing a stop-loss or excess loss insurance contract relating to health claims (as long as the requirements of 45 CFR 164.514 are met);

(v) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(vi) business planning and development, such as conducting cost-management and planning which pertain to running the Plan, including developing and administering formularies and administering, developing or improving methods of payment or coverage policies; and

(vii) business management and general Plan administrative activities, including but not limited to:

(I) management activities related to HIPAA privacy compliance;

(II) customer service, including providing data analysis for plan sponsors, as long as PHI is not disclosed in the process;

(III) resolution of internal grievances;

(IV) merger or consolidation of the Plan with another health plan, and due diligence related to the merger or consolidation; and

(V) consistent with the requirements of 45 CFR 164.514, creating de-identified health information or a limited data set.

Health Care Provider. The term “Health Care Provider” means a provider of services, including a provider of medical or health services, as defined in the Social Security Act, and any other
person or organization that furnishes, bills, or is paid for health care in the normal course of business.

**Health Information.** “Health Information” means any information, whether oral or recorded in any form or medium, that:

1. is created or received by a Health Care Provider, health plan, public health authority, the Employer, life insurer, school, university or health care clearing house; and

2. relates to the past, present or future physical or mental health or condition of an Individual, the provision of health care to an Individual, or the past, present or future payment for the provision of health care to an Individual.

**Health Insurance Issuer.** The term “Health Insurance Issuer” means an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a state and is subject to state law that regulates insurance. The term does not include a group health plan.

**Individual or Individuals.** An “Individual” is the person who is the subject of PHI.

**Individually Identifiable Health Information.** The term “Individually Identifiable Health Information” means Health Information, including demographic information, taken from an Individual which either identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.

**Payment.** “Payment” means:

1. the activities of the Plan (or another health plan) to obtain premiums or to determine or fulfill its responsibility for coverage or providing benefits; or

2. the activities of the Plan or a Health Care Provider to obtain or provide reimbursement for providing health care.

**Privacy Rule or Rules.** The terms “Privacy Rule” or “Privacy Rules” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, Subparts A and E.

**Protected Health Information.** The term “Protected Health Information” means Individually Identifiable Health Information, excluding information contained in employment records of the Employer, that is transmitted or maintained in any form or medium.

**Summary Health Information.** The term “Summary Health Information” means information that may be Individually Identifiable Health Information that summarizes the claims history, claims expenses, or type of claims experienced by Individuals under the Plan, and from which information described in 45 CFR 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.
**HIPAA SECURITY**

**Preamble.** This Article is to allow the St. John’s University Point-of-Service Plan (the “Plan”) to disclose Electronic Protected Health Information to St. John’s University (“Employer”) in certain situations as permitted by HIPAA. This Article allows the Employer to create, receive, maintain or transmit Electronic Protected Health Information (“ePHI”) in certain circumstances on behalf of the Plan.

**Safeguards.** The Employer will put into place and follow Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any ePHI that the Employer creates, receives, maintains or transmits on behalf of the Plan, except as stated below.

**Adequate Separation.** The Employer will put into place and follow reasonable and appropriate security measures to ensure that access to and use of ePHI is restricted to its employees or group of employees who are required to Access or use such ePHI for the proper administration of the Plan, or for such other reasons as may be proper under HIPAA Security Rules. The Employer will provide an effective mechanism for resolving any issues of non-compliance with such Security measures by ensuring that appropriate sanctions are imposed against any employee who violates or fails to follow them.

**Control of Agents and Subcontractors.** The Employer will require that any of its agents or subcontractors to whom it provides ePHI relating to the Plan, agrees to implement reasonable and appropriate security measures to protect the ePHI.

**Reporting Security Incidents.** The Employer will report to the Plan any Security Incident of which it becomes aware.

**Exceptions.** The terms of this HIPAA Security Article shall not apply if ePHI is disclosed to the Employer pursuant to an Authorization which meets the requirements of the HIPAA Privacy Rules described at 45 CFR § 164.508, or if the ePHI is Summary Health Information which the Employer has requested in order (a) to obtain premium bids from health insurers for providing health insurance coverage under the Plan; or (b) to amend or terminate the Plan. In addition, the terms of this HIPAA Security Article shall not apply if the ePHI disclosed to the Employer is information concerning whether an Individual is participating in the Plan.

**Definitions.**

**Access.** “Access” means the ability or the means necessary to read, write, modify or communicate data/information or otherwise use any system resource.

**Administrative Safeguards.** “Administrative Safeguards” are administrative actions and policies and procedures, to manage the selection, development, implementation and maintenance of security measures to protect Electronic Protected Health Information, and to manage the conduct of the Plan or their workforce in relation to the protection of that information.

**Electronic Protected Health Information.** “Electronic Protected Health Information” or “ePHI” is Protected Health Information which is transmitted by Electronic Media or maintained in
Electronic Media. For this purpose the term “Electronic Media” means (i) electronic storage media, including memory devices and computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disc, optical disc or digital memory card; or (ii) transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including transmissions of paper, via facsimile and of voice, via telephone, are not considered to be transmissions via Electronic Media, because the information being exchanged did not exist in electronic form before the transmission.

Health Information. “Health Information” means any information, whether oral or recorded in any form or medium, that:

1. is created or received by a health care provider, health plan, public health authority, employer, life insurer, school, university or health care clearing house; and

2. relates to the past, present or future physical or mental health or condition of an Individual, the provision of health care to an Individual, or the past, present or future payment for the provision of health care to an Individual.

HIPAA Privacy Rule or Rules. The terms “HIPAA Privacy Rule” or “HIPAA Privacy Rules” shall mean the Standards for Privacy of Individually Identifiable Health Information published at 45 CFR Parts 160 and 164, subparts A and E.

Individual. An “Individual” is the person who is the subject of Protected Health Information.

Individually Identifiable Health Information. The term “Individually Identifiable Health Information” means Health Information, including demographic information, taken from an Individual which either identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.

Physical Safeguards. “Physical Safeguards” are physical measures, policies, and procedures to protect the HIPAA Plan(s)’ electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion.

Protected Health Information. The term “Protected Health Information” means Individually Identifiable Health Information, excluding information contained in employment records of the Employer, that is transmitted or maintained in any form or medium.

Security Incident. “Security Incident” means an attempted or successful unauthorized Access, use, disclosure, modification or destruction of information or interference with system operations in an information system.

Summary Health Information. The term “Summary Health Information” means information that may be Individually Identifiable Health Information that summarizes the claims history, claims expenses, or types of claims experienced by Individuals under the Plan, and from which information described in 45 CFR 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.

Technical Safeguards. “Technical Safeguards” mean the technology and the policies and procedures for its use that protect Electronic Protected Health Information and control Access to it.
ST. JOHN’S UNIVERSITY BENEFIT EXCEPTIONS POLICY

RATIONALE

St. John’s University (the “University”) recognizes that, at times, physicians will recommend or perform procedures or prescribe medications that are not covered by Oxford as part of the Point-of-Service Plan (“Plan”). This Benefit Exceptions Policy (“Policy”) allows the University to pay a benefit after it has been denied on appeal with Oxford due to a conflict between what Oxford decides is covered by the Plan and what a physician has recommended as “medically necessary.” This Policy is applicable when Oxford has issued a final denial of a benefit claim made under the procedures specified by the Plan, or in the extraordinary instance where a participant has incurred unusual expenses due to a life-threatening illness. Requests for benefit exceptions must be accompanied with appropriate documentation to support the request on the basis of medical necessity. Each Request will be evaluated on an individual nondiscriminatory basis by a Committee to determine whether or not the claim will be paid under the Policy. Plan participants seeking to have benefit claims paid under this Policy will be notified in writing of the Committee’s final decision, which shall be binding on all parties.

This Policy does not replace the Plan’s claim review procedure, which includes an initial claim determination and appeal process through Oxford. Any Request submitted under this Policy must be made in writing, and the Request must be accompanied by a written waiver agreement which must include an agreement not to sue the University in the event the Request is denied in whole or in part. If a claim is approved under this Policy, Oxford will process the benefit exception through its claims operations, and the University will remit funds to cover the benefit. All benefits paid under this Policy will be paid outside of the Plan, and University and employee contributions required under the Oxford Plan will not be used to pay any benefits under this Policy. Rather, the University will fund payments of claims approved under this Policy through the self-funded bank account used for payment of claims under the Oxford Plan. Claims paid under this Policy should be subject to the same favorable income tax treatment as any claims that are paid under the Plan’s normal procedures. All benefit exceptions approved for payment under this Policy will be paid with non-Plan assets, and the University will maintain records of all claims paid under this Policy.

PROCESS

1. A claimant who has been with the University for at least 1 year whose claim for benefits is denied after an appeal under the Plan’s claim review procedure may submit an exception claim request form (a “Request”) to the University’s Benefits Office. Each Request must (i) identify the procedure or medication at issue; (ii) acknowledge that the procedure or medication is not covered under the terms of the Plan; (iii) state that the claimant has completed the two levels of appeals through Oxford, both of which were denied; and (iv) enumerate the unique facts and circumstances supporting the decision to cover the procedure or medication.

2. The Request form must be accompanied by a completed written waiver agreement as well as a HIPAA authorization.
3. All Requests will be reviewed by a Committee. The Committee may obtain information from the prescribing practitioner to support the Request on the basis of “medical necessity.” Such information may be obtained orally and/or in writing. The Committee may also obtain and rely upon the advice of physicians of appropriate specialties in arriving at its decision. All Requests submitted under this Policy will be reviewed on a nondiscriminatory basis. All decisions will be based on the merit of the medical claim and the potential cost implications.

4. The Committee will normally complete its review of a Request within 60 days (if a review by Best Doctors Network is requested, the timeframe may be extended) and notify the claimant in writing of its decision. The Committee’s decision on any Request will be final and binding as to all parties and a detailed explanation is not required.

APPROVAL COMMITTEE

A Committee will review all requests brought under this Policy based on the “medical necessity” of the procedure or medication at issue and the potential cost implications. Requests brought by senior level management personnel will be reviewed by the Committee but must be approved by the President. If an exception request is made by the President, the Audit and Compensation Committee of the Board of Trustees will need to approve. Requests brought by any other participant will be reviewed by a Committee consisting of the Senior Vice-President-Human Resources and the Director of Benefits. The appropriate Committee will review all supporting documentation, including the opinion and treatment plan of the employee’s treating physician, in making its determination. The Committee’s decision will be final and binding as to all parties.

WAIVER CONDITION

All persons requesting payment of a claim under this Policy must sign a written waiver agreement. Payments under this Policy are conditioned upon the participant’s and any related claimant’s written waiver of any right to sue the University or any of its officers, employees or agents in the event that the claimant alleges that (i) he or she or any of his or her family members has been harmed as a result of any procedure or medication provided under this Policy; or (ii) his or her claim was denied under this Policy. Furthermore, any person who claims a benefit under this Policy must acknowledge that all decisions made under this Policy are final and binding as to all parties.

RIGHT TO REVIEW

The University reserves the right to review extraordinary claims by participants suffering from life-threatening illnesses who were not afforded a final appeal process through Oxford. Such a case might occur (for example) where a participant, who has been diagnosed with a life-threatening condition, goes out-of-network to a center of excellence for treatment, and then incurs the normal 80/20 out-of-network expense split with Oxford. In that case, Oxford, after paying its portion of the out-of-network expense, will not review an appeal for the participant’s claim for reimbursement or payment of his or her portion of the expense, and the participant may be left with costs that greatly exceed the “usual and customary” amount. In that instance, the
University may, at its discretion, review the claim under this Policy. The University may (but shall not be obligated to) review such a claim under this Policy, all participants must sign a written waiver agreement, and the University’s decision will be final and binding as to all parties.