

**SUMMARY PLAN DESCRIPTION  
FOR  
ST. JOHN'S UNIVERSITY WELFARE BENEFIT PLAN**

Effective as of January 1, 2014

## TABLE OF CONTENTS

	<u>Page No</u>
<b>SECTION 1 INTRODUCTION.....</b>	1
Introduction.....	1
<b>SECTION 2 Definitions.....</b>	1
Definitions.....	1
<b>SECTION 3 BENEFITS, CONTRIBUTIONS AND SUBROGATION.....</b>	4
Benefit Plans .....	4
Contributions.....	4
Funding .....	4
Subrogation.....	4
<b>SECTION 4 ELIGIBILITY AND PARTICIPATION .....</b>	6
Eligibility Requirements .....	6
Initial Enrollment .....	6
Annual Enrollment Period .....	6
HIPAA Special Enrollment Period .....	7
Other Mid-Year Enrollment Changes Period.....	7
Participation During Military Leave of Absence.....	7
Participation During FMLA Leave .....	8
Termination of Participation In This Plan.....	9
Nondiscrimination Requirements .....	9
<b>SECTION 5 CLAIMS AND APPEALS PROCEDURES.....</b>	10
Claims Procedures For Health Coverage Benefits.....	11
Claims for Life Insurance, AD&D or Business Travel Accident Benefits .....	13
Claims for Long-Term Disability Benefits .....	13
Appealing A Claim Denial.....	14
Special Timing Rule Governing Appeals of Health Coverage Benefit Claims .....	15
How Long May It Take To Decide An Appeal.....	15
Contents Of The Appeal Decision .....	15
<b>SECTION 6 COBRA CONTINUATION COVERAGE.....</b>	16
What is COBRA Continuation Coverage?.....	17
When is COBRA Coverage Available?.....	17
You Must Give Notice of Some Qualifying Events.....	18
How Is COBRA Coverage Provided?.....	18
If You Have Questions.....	20
<b>SECTION 7 HIPAA PRIVACY and SECURITY.....</b>	20
HIPAA Privacy Rules Applicable to Health Coverage Under the Plan.....	20
HIPAA Security Rules Applicable to Health Coverage Under The Plan .....	23
<b>SECTION 8 PLAN ADMINISTRATION.....</b>	24
Responsibilities For Plan Administration .....	24
Amendment or Termination of the Plan .....	24

SECTION 9 MISCELLANEOUS PROVISIONS .....	25
No Guarantee Of Employment .....	25
Qualified Medical Child Support Orders (QMCSOs).....	25
Newborns' and Mothers' Health Protection Act.....	25
Women's Health and Cancer Rights Act .....	25
Mental Health Parity Act .....	26
SECTION 10 STATEMENT OF ERISA RIGHTS .....	26
SECTION 11 GENERAL PLAN INFORMATION.....	28
APPENDIX A FOR 2014 .....	A-1
APPENDIX A FOR 2015 .....	A-1
APPENDIX B .....	B-1

## **SECTION 1 INTRODUCTION**

### **INTRODUCTION**

St. John's University (the "Employer") has established a variety of health and welfare benefits plans (each considered a "Component Benefit Plan") for the exclusive benefit of employees and their eligible dependents. These health and welfare benefit plans have been bundled together into this single plan, referred to as the St. John's University Welfare Benefit Plan.

This document, together with the appendices and in conjunction with any applicable enrollment information, schedules of benefits, or separate certificate of coverage booklets issued to you by the insurance carriers for the Component Benefit Plans, make up this document referred to as the Summary Plan Description or "SPD," as required by ERISA.

Please note that this SPD provides only a general summary of the Plan and the benefits offered under the Plan. It is not meant to interpret, extend or change the Plan in any way. In case of any conflict between the Plan document and this SPD, the terms of the Plan document will control. In the event of a conflict between either this SPD or the Plan document and the actual insurance contract, the insurance contract will control.

We recommend that you read this SPD carefully so that you understand the Plan's operation and the benefits available to you. A definition section has been provided within this document to help you better understand the meaning of any capitalized words used within the document.

St. John's University and its successor(s) reserve the right to change, amend or discontinue the Plan or any Component Benefit Plan offered under the Plan at any time with or without notice.

## **SECTION 2 DEFINITIONS**

### **DEFINITIONS**

The following capitalized terms are used within this document and have the following meanings:

**Annual Enrollment Period** is the enrollment period each year when you may make changes to your benefit elections and/or add or drop dependents.

**AD&D** means any Accidental Death and Dismemberment insurance offered under this Plan.

**Beneficiary** means an individual you designate, as provided under the terms of each applicable Component Benefit Plan, who is or may become entitled to a benefit under this Plan.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, which provides for continuation of health-related coverage in certain circumstances.

**Code** means the Internal Revenue Code of 1986, as amended from time to time.

**Committee** means the Director of Employee Benefits, appointed by the Employer to act as the Plan Administrator.

**Component Benefit Plan(s)** means the Employer-sponsored health and welfare benefit plans that have been wrapped into this Plan, as listed in Appendix A.

**Contract Administrator** means the third party administrator who has contracted with the Employer to make determinations on and reimburse self-funded claims that have been incurred during the Plan Year.

**Dependent** means, with respect to any Component Benefit Plan provided under this Plan, the meaning given such term under the applicable Component Benefit Plan to which it relates. However, in order to pay the premium cost of any dependent coverage on a pre-tax basis, your dependent(s) must be either your Spouse or Tax Dependent.

**Dependent Care FSA** means the dependent care flexible spending account established by the Employer under a separate document as a separate Component Benefit Plan. It is designed to reimburse eligible dependent care-related expenses incurred by qualifying individuals during the Plan Year. It is not a benefit plan subject to ERISA.

**Effective Date** means January 1, 2014, the date of this SPD.

**Eligible Employee** means a common-law employee of the Employer or a Participating Employer who satisfies the eligibility provisions outlined in Section 4 and who is not excluded from participation by the terms of the applicable Component Benefit Plan.

For purposes of this Plan, an Eligible Employee shall not include (1) any employee who is included in a unit covered by a collective bargaining agreement between employee representatives and the Employer unless the bargaining agreement specifically requires participation in this Plan; or (2) any person retained directly or through a third party to perform services for the Employer (for either a definite or indefinite duration) as a temporary or leased employee, independent contractor, consultant or in any similar capacity, to the extent that any such person is or has been determined to be an employee of the Employer for any purpose, including tax withholding, employment tax, employment law or for purposes of any other employee benefit plan of the Employer.

**Employer** means St. John's University or its successor(s) that continue to maintain the Plan, and if appropriate, the term Employer shall also mean a Participating Employer that is the employer of a particular Participant.

**ERISA** means the Employee Retirement Income Security Act of 1974, as amended from time to time.

**FMLA or FMLA Leave** means a leave of absence provided to an employee of the Employer under the Family and Medical Leave Act of 1993, as amended from time to time.

**Health Care FSA** means the Health Care Reimbursement Account established by the Employer under a separate document as a separate Component Benefit Plan. It is designed to reimburse eligible health-related expenses incurred by you, your Spouse or your Tax Dependents during the Plan Year.

**Health Coverage** means any medical, dental, or Health Care FSA coverage extended under the Plan.

**HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as amended.

**Insurer** means the insurance company who has contracted with the Employer to insure and pay eligible claims incurred by you and/or your Dependents.

**IRS** means the Internal Revenue Service.

**Late Enrollee** means an individual who enrolls on a date other than when first eligible, during the Initial Enrollment Period, or during a HIPAA Special Enrollment Period.

**Participating Employer** means an Employer that adopts this Plan and participates in this Plan for the benefit of its Eligible Employees, pursuant to approval of such participation by St. John's University. Any additional Participating Employers will be listed in Appendix C.

**Participant** means an Eligible Employee, Dependent or Beneficiary who is eligible for or receiving a benefit under this Plan, by virtue of her or his participation in any Component Benefit Plan offered under this Plan.

**Plan** means the St. John's University Welfare Benefit Plan, as amended or restated from time to time.

**Plan Administrator** means the Director of Employee Benefits who has been appointed by the Employer to oversee and carry out the administration of the Plan.

**Plan Sponsor** means the Employer.

**Plan Year** means each twelve-month period beginning on January 1 and ending on the December 31 that follows.

**Spouse** means your current, legal spouse, as determined under the law of the state in which the ceremony took place.

**Tax Dependent** means either of the following:

- A “qualifying child,” meaning someone who:
  1. bears a familial relationship with you (your son, daughter, stepchild, sibling or step-sibling, or their descendant, and including an adopted child lawfully placed with you);
  2. is younger than you, if you are claiming her or him for tax purposes;
  3. lives with you for more than  $\frac{1}{2}$  of the taxable year;
  4. does not provide over  $\frac{1}{2}$  of her or his own support during the year;
  5. has not filed a joint return (other than for a tax refund) for the taxable year; and
  6. is under age 19 (or under age 24 as of the end of the calendar year, if a full-time student) or is a child at any age if permanently and totally disabled. This also includes a child who is entitled to coverage under a Qualified Medical Child Support Order (QMCSO).
- A “qualifying relative,” meaning any individual:
  1. who bears a familial relationship with you (child, grandchild, sibling or step-sibling, parent or step-parent, nephew/niece, aunt/uncle, or in-law) or who lives with you as part of your household for the entire taxable year, provided her/his relationship with you does not violate local law;
  2. for whom you provide over  $\frac{1}{2}$  of her or his support for the calendar year;
  3. who is not the “qualifying child” (for tax purposes) of you or any other individual for the taxable year; and

4. for the calendar year, the individual does not earn more than the exemption amount described in Code Section 151(d), which for 2014 is \$3,950.
- Tax Dependent will also include your child who is receiving medical or Health FSA coverage under this Plan, up through the end of tax year in which your child attains age 26, regardless of whether your child meets the residency, support or other tests described above.

Note that some individuals may qualify as your Tax Dependents, but may not be eligible for every Component Benefit Plan offered under this Plan.

## **SECTION 3** **BENEFITS, CONTRIBUTIONS AND SUBROGATION**

### **BENEFIT PLANS**

All of the Component Benefit Plans currently offered under this Plan are listed in the attached Appendix A. For a detailed description of any Component Benefit Plan offered under this Plan, please refer to the actual certificates of coverage booklets, benefit summaries, or other enrollment materials provided by the Insurer or Plan Administrator for the Component Benefit Plans that are incorporated under this Plan by reference. The eligibility and participation rules of the Plan are in addition to and do not supersede any rules imposed by the Insurer.

### **CONTRIBUTIONS**

The Plan Administrator may require you to contribute toward the cost of certain Component Benefit Plans offered under this Plan in order for you to participate in those Component Benefit Plans. Any employee contributions required in order to participate in any Component Benefit Plan offered under this Plan shall be set out in a separate document and made available to you by the Plan Administrator at the time of enrollment, or upon request.

Should a change in the cost of any Component Benefit Plan be required during the Plan Year (for example, due to a change in the overall cost of the coverage paid by the Employer), the amount of your contribution will be adjusted automatically.

### **FUNDING**

The Component Benefit Plans offered under this Plan may be either fully-insured or self-funded by the Employer. If they are fully-insured, it means that an insurance carrier (the "Insurer") has issued a contract with the Employer, and is responsible for financing and administering the Component Benefit Plan, and for guaranteeing payment of eligible claims incurred while covered under the Component Benefit Program. Alternatively, if a Component Benefit Plan is self-funded, it means that the Employer has assumed the risks associated with offering the coverage and that claims will be paid from the Employer's general assets or a trust. The Employer assumes this risk, even if the Employer contracts with a third party or claims payment service to help administer the payment of claims.

### **SUBROGATION**

In some cases, another individual, insurance policy or plan – such as an auto or liability insurance policy or another group plan or HMO – may be obligated to pay some or all of your Health Coverage expenses.

In these cases, you or your covered Dependents have the right to recover some or all of your eligible expenses from those sources, rather than from the Plan.

In these cases, the Plan is “subrogated” in your or your covered Dependent’s right to recover, and has the right to recover these amounts from you or your covered Dependent if such amounts are recovered from the liable third party or its insurer. The Plan may assert this right independently of you or your covered Dependent. You or your covered Dependent may request for the Plan to pay benefits for your or your covered Dependent’s covered expenses, but you or your covered Dependent must give written consent for the Plan to recover those expenses from the other insurance policy or plan, and you must agree to pay over to the Plan any amount that you recover from a responsible party.

You or your covered Dependent must also cooperate in all respects with the Plan’s effort to recover, including providing the Plan with any relevant information, signing and delivering any documents the Plan reasonably requests to secure its subrogation claim, and obtaining the Plan’s consent before releasing any party from liability for payment of medical expenses.

If you or your covered Dependent receives an amount to compensate you for injuries which the Plan has paid for (even if these injuries are not specifically mentioned), you or your covered Dependent is obligated to repay the Plan. Further, you or your covered Dependent will hold these amounts in trust or a constructive trust for the benefit of the Plan. The Plan does not take into account state law doctrines such as limitations on its rights to recover in cases where you or your covered Dependent has not been fully compensated for your injuries. Furthermore, the Plan will not be responsible for paying any part of your or your covered Dependent’s legal fees in connection with recovering any covered expenses.

If another party is legally responsible or agrees to provide any compensation, you or your covered Dependent (or legal representatives, estate, heirs or trusts established on behalf of either you or your covered Dependent), must promptly reimburse the Plan for any benefits it paid relating to that illness or injury, up to the full amount of the compensation received from the other party (regardless of how that compensation may be characterized and regardless of whether you or your covered Dependent have been made whole). The Plan may reduce or deny current or future benefits on the basis of the compensation received or constructively received by the you, your covered Dependent(s) or representative(s).

In order to secure the rights of the Plan under this section, you or your covered Dependents:

- Grant to the Plan a first priority lien against the proceeds of any such settlement, verdict or other amounts received by you, your covered Dependent or representative;
- Assign to the Plan any benefits you or your covered Dependent may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement; and
- Agree that you, your covered Dependent, or representative will hold any compensation in constructive trust for the benefit of the Plan and all its participants who have contributed to the funding of the Plan.

The Plan may reduce or deny current or future benefits on the basis that you or your covered Dependent has refused to sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement or refused to reimburse the Plan from the proceeds of your settlement verdict. If you or your covered Dependent enter into litigation or settlement negotiations regarding the obligations of other parties, you or your covered Dependent must not prejudice, in any way, the subrogation rights of the Plan under this section.

## **SECTION 4**

### **ELIGIBILITY AND PARTICIPATION**

To become a “Participant” in the Plan, you and your Dependents must meet certain eligibility and enrollment requirements, which are summarized below. You should also refer to any Component Benefit Plan summaries (e.g., certificate of coverage booklet, benefit summary, etc.), incorporated by reference.

#### **ELIGIBILITY REQUIREMENTS**

To participate in any of the Component Benefit Plans offered under this Plan, you must be and remain either an Eligible Employee or the Dependent of an Eligible Employee. Generally, regular active full-time employees (working 30+ hours/week) are eligible to participate in the Component Benefit Plans offered under this Plan. However, you should refer to Appendix B for specifics on any hours or other requirements necessary to be considered eligible for coverage under the Component Benefit Plans offered under this Plan.

No individual may participate whose participation has been terminated for cause or for any other reason listed in the “Termination of Coverage” section of this document.

#### **INITIAL ENROLLMENT**

You will become a Participant in the Plan automatically when you enroll or begin participating in any Component Benefit Plan offered under this Plan. However, participation in some Component Benefit Plans is not automatic. In order to participate in those Component Benefit Plan, you may be required to complete and submit written election forms to the Plan Administrator before becoming a Participant. For those Component Benefit Plans requiring a written election, your initial election to participate must be made and submitted to the Plan Administrator not later than 31 days after first becoming eligible to participate. If you do not timely make and submit any written election to the Plan Administrator within the 31-day period, you will be deemed to have elected not to participate in the Component Benefit Plan. You must then wait until the next Annual Enrollment Period to elect coverage, unless you qualify for a mid-year enrollment opportunity, as described below under the HIPAA Special Enrollment Period or Other Mid-Year Enrollment Change Period.

#### **ANNUAL ENROLLMENT PERIOD**

If you did not apply for coverage during the Initial Enrollment Period or a HIPAA Special Enrollment Period, you may apply for coverage during any Annual Enrollment Period. The Plan Administrator must receive the enrollment or change notice through the methods approved by the Plan Administrator within the specified time period. This is an enrollment period which occurs annually, generally during the months of November and December of each year, at which time you may enroll (if otherwise eligible) or make election changes to your coverage under the Component Benefit Plans offered under this Plan for yourself or your eligible Dependents. Any election changes made during this Annual Enrollment Period become effective the first day of the following Plan Year. If you do not enroll or change your coverage selections during the Annual Enrollment Period, you must wait until the next Annual Enrollment Period, unless you are eligible to become enrolled due to special circumstances, as outlined below.

## **HIPAA SPECIAL ENROLLMENT PERIOD**

*This is applicable only to medical, dental and health FSA coverage, but not to any other Component Benefit Plan offered under this Plan (e.g., life, disability, etc.).*

If you, your Spouse and/or eligible Dependents are entitled to special enrollment rights, you may change your group health coverage elections to correspond with the special enrollment right. For example, if you declined enrollment in the medical plan offered under this Plan for yourself or your eligible Dependents because you or they had other medical coverage and eligibility for such other coverage is subsequently lost (for example, due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA coverage), you may be able to elect medical coverage under the Plan for yourself and your eligible dependents who lost such coverage. You must request enrollment *in writing* within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage)

In addition, you may make a change to your health coverage due to your marriage or the birth, adoption or placement for adoption of a child with you. Written requests received within 31 days of the birth of a child or adoption or placement for adoption of a child with you will permit you, your child(ren) and your Spouse, if elected, to be covered retroactively to the date of birth, adoption or placement for adoption. Written requests received within 31 days of your marriage will permit you, your Spouse and your Dependent children, if elected, to be added to your coverage, at your election, retroactively to the date of the marriage or prospectively as of the date of your request.

You may also cancel or modify your medical insurance during the current Plan Year if the reason for canceling or modifying your election is on account of your, your Spouse and/or your eligible Dependent (i) losing coverage under a Medicaid Plan under Title XIX of the Social Security Act; (ii) losing coverage under a State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or (iii) becoming eligible for group health plan premium assistance under Medicaid or SCHIP. However, to cancel or modify your medical insurance, you must make a written election to the Plan Administrator no later than 60 days after the loss of coverage or eligibility for premium assistance.

An individual who loses coverage as a result of either a failure to pay premiums on a timely basis or for cause (such as for making a fraudulent claim or an intentional misrepresentation of a material fact in connection with prior health coverage) does not have the right to enroll under this Subsection.

## **OTHER MID-YEAR ENROLLMENT CHANGES PERIOD**

Generally, you cannot change the enrollment elections you have made after the beginning of the Plan Year, other than during an Annual Enrollment Period or HIPAA Special Enrollment Period. However, there are certain other limited situations when your enrollment elections may be changed during the Plan Year, such as if you experience a change in your employment or family status. Please review your Flexible Spending Account and Premium Only Plan SPD for more information regarding the events that may permit a mid-year enrollment change under this Plan.

## **PARTICIPATION DURING MILITARY LEAVE OF ABSENCE**

When you or your covered family member would otherwise lose coverage under the Plan due to leave for full-time active duty in the US military, you may ask to extend all Plan coverage, including dependent coverage, for up to 24 months or the length of your military service, whichever is shorter, as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA). The Plan's policies

and procedures require that you provide notice of any military service within a reasonable period of time in order to be eligible for USERRA continuation coverage. You should provide written notice to your employer as soon as possible, however, in many circumstances, oral notice will be sufficient. This entitlement will end if you provide written notice of your intent not to return to work following the completion of military leave.

If you elect to continue coverage under the Plan due to military leave, you may be required to pay up to 102% of the full contribution under the Plan, except that if you are on active duty for 30 days or less, you cannot be required to pay more than the active employee share of the premium, if any, for the coverage. An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of your military leave.

Questions concerning your Plan or your USERRA continuation coverage rights should be addressed to the individual(s) identified in the Plan Information Section of this SPD. For more information about your rights under USERRA, contact the Regional or District Office of the U.S. Department of Labor's Veterans' Employment and Training Service (VETS) in your area or contact VETS at 1-866-4-USA-DOL or visit their website at <http://www.dol.gov/vets>.

## **PARTICIPATION DURING FMLA LEAVE**

Under FMLA, you are entitled to continue all Plan coverage during the period of leave if such coverage was in effect prior to the date on which the leave began. However, you have different options with regard to your coverage, depending upon whether the FMLA Leave is paid leave or unpaid leave.

### If FMLA Leave is Paid Leave

If you commence FMLA Leave that is paid leave, you will be required to continue any existing coverage for yourself and your Dependents during your period of paid leave (without interruption). Any Employee contributions applicable to your coverage (and that of your Dependents) that would normally be deducted through salary reduction when you are regularly scheduled to work will continue to be deducted from your pay while on paid FMLA leave to the same extent as would be deducted for any other paid leave (e.g. on a pre-tax salary reduction basis).

### If FMLA Leave is Unpaid Leave

If you commence FMLA Leave that is unpaid leave, you may either (a) continue your existing coverage during your period of leave, or (b) elect to revoke or terminate your coverage during your period of unpaid FMLA leave.

If you continue your coverage during your leave, any required contributions due and payable during your period of leave must be paid to your Employer, as determined by your Employer, either by:

1. Prepaying the premiums out of any pre-leave compensation;
2. Paying the premiums on a "pay-as-you-go" basis with after-tax monthly payments; or
3. Catching up premiums after you return from leave. Catch-up contributions made following leave may be made on a pre-tax salary reduction basis (if applicable) from any available taxable compensation paid in the same plan year as your leave (including from unused sick days and vacation days) or on an after-tax basis.

If you revoke or terminate your and your Dependents' coverage during your leave, or if coverage is cancelled during your leave due to nonpayment of premiums, upon return from leave you may either:

1. reinstate your prior elections; or
2. make new elections.

#### General Rules Applicable to FMLA Leaves (Whether Paid or Unpaid)

If an Annual Enrollment Period occurs while you are on FMLA leave, you will be provided with any applicable enrollment materials and extended the opportunity to elect any change in benefits during your leave to the same extent as any similarly situated active employee.

### **TERMINATION OF PARTICIPATION IN THIS PLAN**

Participation in this Plan will end on the earliest:

- The date your employment with the Employer terminates, unless you qualify for retiree medical insurance;
- The end of the month that you cease to be an eligible Employee;
- The date of your death; or
- The date the Plan is terminated by the Employer.

If your employment with the Employer ends, or you cease to meet the eligibility requirements of the Plan, your participation in the Plan will be terminated and typically, your contributions (whether pre-tax or after-tax) will continue through your last regular payroll period. If the Employer terminates the Plan, your coverage under the Plan will end effective the date of termination.

Suspension of or disqualification, denial, loss or forfeiture of any benefits under any Component Benefit Plan will be specified within the certificate of coverage booklets, benefit summaries, etc. provided for each Component Benefit Plan.

Termination of participation in the Plan will not affect any rights you or your Spouse and/or eligible Dependents may have to continue participation in certain Health Coverage. Please see the COBRA Continuation Coverage section that appears later in this document.

### **NONDISCRIMINATION REQUIREMENTS**

To the extent that any Component Benefit Plan provides health coverage, such group health plan and issuer may not establish rules for eligibility of any individual (including continued eligibility) to enroll under the terms of the health plan based on any "health status-related factors." In other words, the group health plan may not deny your eligibility to participate on the basis of factors such as your medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. Additionally, you cannot be required to pay a greater premium or contribution than that of similarly situated individuals just because of your health-status (except for premium discount programs under a bonafide wellness program).

## **SECTION 5**

### **CLAIMS AND APPEALS PROCEDURES**

The following claims procedures shall apply, but only to the extent not otherwise provided under the applicable Component Benefit Plans' documents. If the claim and appeal rules in this document apply, they shall be construed and applied in a manner consistent with Department of Labor regulation § 2560.503-1 as in effect on the date the claim was received. To the extent that a conflict exists in the insurance contracts or administrative agreements, the provisions of the foregoing regulations will control.

An individual making a claim for benefits under the Plan ("the Claimant"), at all steps of the claims process, may be represented by another person, who may be, but is not required to be, a lawyer. The Claimant will be responsible for paying the fees and expenses of his or her representative. The Plan Administrator may require evidence that it considers reasonable to establish that an individual is actually the authorized representative of the Claimant.

Except for claims decisions that it delegates to a Claims Administrator, the Plan Administrator has exclusive responsibility for deciding claims for benefits under the Plan and for deciding any appeals of denied claims. The Plan Administrator has the authority, in its complete discretion and within the scope of its authority, to interpret the terms of the Plan, including any insurance policies, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Plan Administrator shall be final and binding on the Claimant to the fullest extent permitted by law.

Unless otherwise specified in any applicable Component Benefit Plan document, all claims must be submitted for payment with complete information within a specified time from the date upon which such claim was incurred. That specified time is 15 months for dental claims, 6 months for out-of-network Oxford medical claims, 90 days for life, AD&D and long-term disability claims and 20 days for business travel accident claims. Claims submitted outside the applicable time limitation shall not be payable under the Plan.

The following definitions apply to this Claims and Appeals Procedures Section:

“Adverse Benefit Determination” means a denial, reduction, or termination of a benefit, including a failure to pay all or part of a benefit claim, whether based on a determination that the Claimant is ineligible to participate in the Plan or based on a utilization review. In addition, any rescission of coverage under the Plan, other than a rescission attributable to a failure to timely pay required premiums or contributions towards the cost of coverage, will be treated as an “adverse benefit determination. Rescission of coverage generally means a cancellation of coverage or discontinuance of coverage that has retroactive effect. Adverse Benefit Determination also includes failure by the Plan to cover an item or service for which benefits are otherwise provided because it is found to be experimental or investigational, or because it is found not to be medically necessary or appropriate.

“Claimant” means any Participant, Beneficiary or Dependent who is making a claim for a benefit.

“Claims Administrator” means a Contract Administrator, Insurer or the Plan Administrator, as applicable.

“Concurrent Claim” means any benefit claim for medical, dental or vision benefits where the Claims Administrator has approved an ongoing course of treatment over a set period of time, or a set number

of treatments, but the Claims Administrator cancels the treatment before the end of that time period or reduces the number of treatments.

“Grandfathered Health Plan” means a group health plan and/or health insurance coverage that was in existence on March 23, 2010, and that had at least one participant on that date. Grandfathered Health Plans are excused from some of the health care reform requirements enacted under the Public Health Service Act (PHSA). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. The medical group health plans offered under this Plan are not “Grandfathered Health Plans” under the Patient Protection and Affordable Care Act (the Affordable Care Act) as of the effective date of this SPD.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

“Post-Service Claim” means any benefit under the Plan that is not a Pre-Service Claim and does not involve urgent care.

“Pre-Service Claim” means any benefit claim on account of which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

“Urgent Care” or “Urgent Care Claim” means any claim for medical care or treatment under the Plan if application of time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the Claimant to regain maximum function; or in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The Claims Administrator or the Plan Administrator will determine if a claim involves Urgent Care by applying the judgment of a prudent layperson possessing an average knowledge of health and medicine. Nevertheless, if a physician with knowledge of the Claimant’s medical condition determines that the claim involves Urgent Care, this decision will control.

## **CLAIMS PROCEDURES FOR HEALTH COVERAGE BENEFITS**

### **Urgent Care Claims**

If a Claimant submits a claim for Urgent Care, the Claims Administrator shall notify Claimant of its determination on the claim as soon as possible, but no later than seventy-two (72) hours after the claim is filed. If the Claimant does not provide the Claims Administrator with enough information to decide the claim, the Claims Administrator shall notify the Claimant within twenty-four (24) hours after it receives the claim of the further information that is needed. The Claimant shall have forty-eight (48) hours to provide that information. If the needed information is provided, the Claims Administrator shall notify the

Claimant of its decision within forty-eight (48) hours after the Claims Administrator received the information. If the needed information is not provided, the Claims Administrator shall notify the Claimant of its decision within one hundred twenty (120) hours after the claim was received. The Claims Administrator may notify the Claimant of its decision by phone and later mail a written notice if the claim is denied.

### **Concurrent Care Claims**

If the Claimant wants to extend the course of a treatment beyond the initial time period or increase the number of treatments and the claim involves Urgent Care, the Claims Administrator shall notify the Claimant of its decision within 24 hours of receipt of the claim, provided that the claim has been made by the Claimant at least 24 hours prior to the end of the treatment time period. If the Claimant wants to extend the course of treatment beyond the initial time period or increase the number of treatments and the claim is not urgent, then the Claims Administrator must notify the Claimant of its decision within 30 days after a request is made. If special circumstances require more time, the Claimant shall be informed in writing (before the end of the 30-day period) of the reason for the delay and the date a decision will be made. In no case will the extension exceed 45 days after the claim is filed.

### **Pre-Service Claims**

If a Claimant submits a Pre-Service claim, the Claims Administrator shall notify the Claimant of its determination on the claim within a reasonable period, but no later than fifteen (15) days after the claim is filed. If an extension of this 15-day period is required due to matters beyond the control of the Plan, the Claims Administrator shall notify the Claimant in writing, prior to the end of the 15-day period, of the circumstances requiring the extension and the date that the Claims Administrator expects to make a decision. The extension period will be no longer than 15 days. If such an extension is necessary due to the Claimant's failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and the Claimant will have at least 45 days from the receipt of the notice within which to provide the necessary information.

### **Post-Service Claims**

If a Post-Service Claim is filed, the Claims Administrator shall have a reasonable period of time, up to 30 days, in which to review the claim and to notify the Claimant of its decision on the claim. If an extension of this 30-day period is required due to matters beyond the control of the Plan, the Claims Administrator shall notify the Claimant in writing, prior to the end of the 30-day period, of the circumstances requiring the extension and the date that the Claims Administrator expects to make a decision. The extension period will be no longer than 15 days. If such an extension is necessary due to the Claimant's failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and the Claimant will have at least 45 days from the receipt of the notice within which to provide the necessary information. If the Claimant or the medical care provider made a mistake in filing the claim, the notice shall tell the Claimant how to correct it.

### **Rules Applicable to All Claims for Health Coverage Benefits**

If the claim is denied, the Claimant shall receive a written notice from the Claims Administrator that will explain the reason for the denial, specify the Plan provisions on which the denial was based, describe the benefit claims procedure and the time limits to appeal the claim, and inform the Claimant of his or her right to bring a civil action under Section 502(a) of ERISA if any appeal of the claim is denied. The notice shall also inform the Claimant if the Claims Administrator relied on any internal rule or guideline when it made its decision, and that a copy of the rule or guideline will be provided to the Claimant free of

charge, upon request. If the Claims Administrator denies the claim because it determines that the claim is not medically necessary or that the treatment used is experimental or investigational, the notice will specify what Plan provision(s) the decision is based on as well as explain any scientific judgments the Claims Administrator made.

If the claim is denied in whole or in part, the Claimant shall be permitted to review his or her claim file, and may appeal the Adverse Benefit Determination using the procedures described below.

Beginning January 1, 2011, non-Grandfathered Health Plans offering Medical Coverage are also subject to an additional, external level of review. For more information regarding this external level of review, please contact the applicable Insurer or Claims Administrator providing the Medical Coverage.

### **CLAIMS FOR LIFE INSURANCE, AD&D OR BUSINESS TRAVEL ACCIDENT BENEFITS**

In the case of claims for life insurance benefits, the Claims Administrator shall notify the Claimant of its determination on the claim no later than 90 days after receipt of the claim by the Claims Administrator, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. If the Claims Administrator determines that an extension of time for processing the claims is required, the Claimant shall be provided with written notice of the extension (of no more than 90 days) prior to the expiration of the initial 90-day period. In no case will the extension exceed 180 days after the date the claim was filed.

If the claim for life insurance benefits under the Plan is partly or entirely denied, the Claimant will receive written notice from the Claims Administrator. The notice will explain the reason for the denial, specify the Plan provisions on which the denial is based, describe the appeals procedure and the time limits to appeal the claim, and inform the Claimant of his or her right to bring a civil action under Section 502(a) of ERISA if any appeal of the claim is denied.

If the claim is denied in whole or in part, the Claimant is entitled to appeal the Adverse Benefit Determination using the procedures described below.

### **CLAIMS FOR LONG-TERM DISABILITY BENEFITS**

In the case of claims for long-term disability benefits, the Claims Administrator shall notify the Claimant of its determination on the claim no later than 45 days after receipt of the claim by the Claims Administrator, unless the Claims Administrator determines that an extension (not to exceed 30 days) is required due to matters beyond the control of the Plan. If the Claims Administrator determines that additional time is required to process the claim, the Claimant must be provided with written notice of the extension prior to expiration of the initial 45-day period. The notice will explain the circumstances requiring an extension.

If prior to the end of the first 30-day extension period, the Claims Administrator determines that due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the Claims Administrator may have an additional 30 days to make a decision. The Claimant will be provided written notice prior to the end of the initial 30-day extension period, explaining the circumstances requiring the additional extension (not to exceed 30 more days) and the date as of which the Claims Administrator expects to render a decision. The extension notice will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. The Claimant will be given at least 45 days within which to provide the information specified in the notice. If the Claimant does not provide additional

information within the time specified, the determination will be made based solely on the available information previously provided. In no case will the extensions exceed 105 days after the date the initial claim was filed.

If the claim is denied, the Claimant will receive a written notice from the Claims Administrator that will explain the reason for the denial, specify the Plan provisions on which the denial was based, describe the benefit claims procedure and the time limits to appeal the claim, and inform the Claimant of his or her right to bring a civil action under Section 502(a) of ERISA if any appeal of the claim is denied. The notice will also inform the Claimant if the Claims Administrator relied on any internal rule or guideline when it made its decision, and that a copy of the rule or guideline will be provided to the Claimant free of charge, upon request.

If the claim is denied in whole or in part, the Claimant is entitled to appeal using the procedures described below.

## **APPEALING A CLAIM DENIAL**

In the case of claims involving Health Coverage and long-term disability claims, the Claimant has 180 days to appeal following the date on which he or she receives notice of an Adverse Benefit Determination. In the case of claims involving life insurance or AD&D, the Claimant has 60 days to appeal following the date on which he or she receives notice of an Adverse Benefit Determination.

The Claimant will be provided, upon request and free of charge, with copies and/or reasonable access to all documents, records and other information relevant to his or her appeal. The Claims Administrator's review must take into account all comments, documents, records, other evidence and testimony, and other information submitted by the Claimant relating to the claim, regardless of whether the information was submitted or considered in the initial benefit determination. The Claims Administrator's review must not give any deference to the initial Adverse Benefit Determination. No individual who took part in the initial Adverse Benefit Determination, nor a subordinate of anyone who took part in the initial Adverse Benefit Determination, may participate in the appeal decision.

If an appeal is based in whole or in part on a medical judgment, including a determination with regard to whether a treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the particular field of medicine involved in the judgment. This professional may not be an individual who was consulted in connection with the initial Adverse Benefit Determination, nor the subordinate of anyone consulted in connection with the initial Adverse Benefit Determination, and no individual who reviews and decides appeals shall be compensated or promoted based on the individual's support of a denial of benefits. The Claims Administrator shall identify and disclose to the Claimant any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination, regardless of whether the advice was relied upon in making the determination. The Claims Administrator will provide a claimant any new evidence considered, generated, or relied upon prior to making a final benefit determination, any new rationale for an adverse benefit determination prior to making a final benefit determination; and will provide required notices in a culturally and linguistically appropriate manner, as directed by the Claims Administrator.

## **SPECIAL TIMING RULE GOVERNING APPEALS OF HEALTH COVERAGE BENEFIT CLAIMS**

In the case of a claim involving Urgent Care under the Plan, the Claims Administrator shall allow the Claimant to submit an expedited appeal either orally or in writing. If an expedited appeal is requested, all necessary information, including the Claims Administrator's determination on review, will be transmitted between the Claims Administrator and the Claimant by telephone, facsimile or other expeditious method.

### **HOW LONG WILL IT TAKE TO DECIDE AN APPEAL?**

The Claims Administrator will decide an appeal from a denied life insurance or AD&D claim no later than 60 days after receipt of the Claimant's request for appeal, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. If special circumstances require a further extension of time for processing a claim, the Claims Administrator must provide the Claimant written notice of the extension prior to the termination of the initial 60-day period. This written notice must describe the special circumstances requiring the extension and the date upon which the appeal will be decided. In no case will the extension exceed 120 days after the appeal is filed.

The Claims Administrator will decide an appeal from a denied long-term disability claim no later than 45 days after receipt of the Claimant's request for appeal, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. If special circumstances require a further extension of time for processing the claim, the Claims Administrator must provide the Claimant written notice of the extension prior to the termination of the initial 45-day period. This written notice must describe the special circumstances requiring the extension and the date upon which the appeal will be decided. In no case will the extension exceed 90 days after the appeal is filed.

If the appeal involves an Urgent Care Claim for Health Coverage benefits under the Plan, the Claims Administrator will notify the Claimant of its decision on appeal as soon as possible taking into account pertinent medical matters and considerations, but in no event later than 72 hours after receipt of the request for appeal.

If the appeal involves a Pre-Service Claim for medical, dental or vision benefits under the Plan, the Claims Administrator will notify the Claimant of its decision on appeal within a reasonable period of time appropriate to the medical circumstances. This period will not exceed 30 days after the date upon which the Claims Administrator received the request for appeal.

If the appeal involves a Post-Service Claim for medical, dental, vision or health care flexible spending account benefits under the Plan, the Claims Administrator will notify the Claimant of its decision on appeal within a reasonable period of time, which will not exceed 60 days after the date upon which the Claims Administrator received the request for appeal.

### **CONTENTS OF THE APPEAL DECISION**

The Claims Administrator's decision will be furnished to the Claimant in writing within the time periods described above. If an appeal is denied in whole or in part, the notice of decision shall set forth, in a manner calculated to be understood by the Claimant, the specific reason or reasons for the denial; reference to the specific plan provisions upon which the denial was based; a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to the claim for benefits; and a statement describing any voluntary dispute resolution options.

If an internal rule, guideline, protocol or other similar criterion was relied upon in denying an appeal, the Claims Administrator must either furnish the Claimant with a copy of the specific rule, guideline, protocol or other criterion, or provide the Claimant with a statement that the rule, guideline, protocol or criterion was relied upon in making the Adverse Benefit Determination, and that a copy of these materials will be provided to the Claimant free of charge. If the denial is based on medical necessity, experimental treatment or a similar exclusion or limit, the Claims Administrator must either furnish the Claimant with an explanation of the scientific or clinical judgment upon which the decision was based, applying the terms of the Plan to the Claimant's case, or a statement that this explanation will be provided free of charge upon request. The decision by the Claims Administrator on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **These claims procedures must be exhausted before any legal action is commenced.**

#### **UNCLAIMED BENEFIT**

If, after any amount becomes payable hereunder to a Participant, Dependent or Beneficiary, the amount shall not have been claimed or any check issued under the Plan remains uncashed after a specified period of time, provided reasonable care shall have been exercised by the Plan Administrator in attempting to make such payments, the amount thereof shall be forfeited and shall cease to be a liability of the Plan. The specified period of time is: 3 months for dental benefits, 12 months for Oxford medical benefits and 180 days for life, AD&D and long-term disability benefits.

### **SECTION 6 COBRA CONTINUATION COVERAGE**

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of Health Coverage under the Plan. **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group Health Coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group Health Coverage. There may also be other health coverage alternatives available to you and your family. When key parts of the Affordable Care Act health care law take effect, you will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another

group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

## **WHAT IS COBRA CONTINUATION COVERAGE?**

COBRA continuation coverage is a continuation of Health Coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for any COBRA continuation coverage elected.

If you are an Eligible Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happen:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happen:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

## **WHEN IS COBRA COVERAGE AVAILABLE?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

## **YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS**

For the other qualifying events (divorce or legal separation of you and Spouse, or a Dependent child's losing eligibility for coverage as a Dependent child), ***you must notify the Plan Administrator within 60 days*** after the qualifying event occurs (within 30 days of loss of Social Security disability status).

An untimely Qualifying Event Notice is considered to have no effect and shall be rejected.

The Plan requires that you provide a Qualifying Event Notice in writing by mail to the Plan Administrator. Under no circumstances will an oral notice be effective.

In the Qualifying Event Notice, you are required to provide certain information regarding the qualifying event such as identification of the type of event, the date the event occurred and the name of the individual to whom the event is applicable. The qualifying events listed below require specific documentation attached to the Qualifying Event Notice:

<b>Qualifying Event</b>	<b>Documentation Required with Notice</b>
Divorce or legal separation	Certified copy of the court order granting the divorce or legal separation.
Death of covered employee	Copy of death certificate.
Qualification for Social Security Disability	Copy of the Social Security Administration determination
Loss of Social Security Disability Status	Copy of Social Security Administration final determination.

To be considered valid, the notice must be completed in full and all required enclosures must be supplied. However, the Plan's Policy provides that a Qualifying Event Notice otherwise received timely, but which does not contain all required information or enclosures will not be considered untimely if the Plan Administrator is able to identify the Plan, identify the covered employee or qualified beneficiary, identify the qualifying event or disability, and identify the date on which the qualifying event occurred. The Plan Administrator, in such event, may require additional supplementary information from the covered employee or qualified beneficiary. The completed Qualifying Event Notice must be mailed to the Plan Administrator. It is recommended that you send the completed Qualifying Event Notice by registered mail, return receipt requested, but it is not required. When you submit a completed Qualifying Event Notice, you need to retain a copy (including copies of all enclosures) and any proof of mailing. If you do not receive a response from Plan Administrator within 14 days of mailing the notice, you must contact the Plan Administrator immediately in writing to determine the status of your COBRA claim.

## **How Is COBRA COVERAGE PROVIDED?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage may be offered to each of the qualified beneficiaries, each of whom has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children.

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing

eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

The COBRA continuation coverage period that applies to the Health care Reimbursement Account may not be the same as the COBRA continuation period that applies to other health care benefits as described above, but may end as of the last day of the Plan Year in which the qualifying event occurs. This is discussed further in the subsection entitled *COBRA Coverage for Employees Participating in a Health Care Reimbursement Account* below.

#### Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To notify the Plan Administrator of the determination by the Social Security Administration that you, your Spouse or your Dependent child is eligible for disability, the Qualifying Event Notice must be completed and returned to the Plan Administrator as described in the section **You Must Give Notice of Some Qualifying Events**. A copy of the determination by the Social Security Administration must be attached to the Qualifying Event Notice.

#### Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any Dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

#### COBRA Coverage for Employees Participating in a Health Care Reimbursement Account

If you are an employee participating in a Health Care Reimbursement Account ("health FSA plan") which is funded in whole or in part through pre-tax payroll deductions, COBRA continuation coverage may apply to you and may apply to your qualified beneficiaries.

You, or your qualified beneficiaries, may have limited COBRA continuation coverage with respect to the health FSA. Your eligibility for this limited COBRA continuation coverage will be determined based on how much of your annual reimbursement amount has been distributed to you as of the date

of the qualifying event. COBRA coverage will not be offered to you if you have “overspent” your excepted health FSA as of the date of your qualifying event. Also, the limited health FSA COBRA continuation coverage period available to qualified beneficiaries who have not overspent their health FSA ends as of the end of the Plan Year in which the qualifying event occurs.

If you have any questions concerning your COBRA continuation coverage with respect to the health care reimbursement plan in which you are participating, you should contact the Plan Administrator.

#### **ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

#### **IF YOU HAVE QUESTIONS**

Questions concerning the Plan or COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa) or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace visit [www.healthcare.gov](http://www.healthcare.gov). You may also write to them at the U.S. Department of Labor; Employee Benefits Security Administration, 200 Constitution Avenue, N.W., Room N-5658, Washington, D.C. 20210.

#### **Keep Your Plan Informed of Address Changes**

In order to protect your family’s rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

### **SECTION 7 HIPAA PRIVACY AND SECURITY**

#### **HIPAA PRIVACY RULES APPLICABLE TO HEALTH COVERAGE UNDER THE PLAN**

This Section 7 describes only the health information privacy and security practices of any Component Benefit Plan offered under this Plan that is subject to HIPAA Privacy and Security rules. For a more complete explanation, please see the individual Notices of Privacy Practices.

The Plan is committed to protecting medical information about you. The Plan may disclose protected health information (PHI) to the Employer under limited circumstances, although this information will be disclosed only upon the receipt of a certification by the Employer that the Plan documents have been amended to incorporate the privacy provisions, and that it will abide by them. The Plan may disclose summary health information to the Employer for the purposes of obtaining premium bids, insurance coverage, or modifying, amending, or terminating the Plan.

The Plan may disclose protected health information to carry out plan administration functions that are consistent under applicable law. The Plan may not disclose PHI to the Employer for the purpose of employment-related actions or decisions in connection with other benefits or employee benefit plans of the Employer. A limited number of employees of the Employer will have access to PHI for the purposes of carrying out plan administration functions in the ordinary course of business.

The following categories describe different ways that the Plan uses and discloses PHI. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

*For Treatment.* The Plan may use or disclose medical information about you to provide you with medical treatment or services by providers. The Plan may disclose PHI about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you at the hospital.

*For Payment.* The Plan may use and disclose PHI about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage.

*For Health Care Operations.* The Plan may use and disclose PHI about you for other Plan operations which are necessary to run the Plan. For example, the Plan may use PHI in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

*As Required By Law.* The Plan will disclose PHI about you when required to do so by federal, state or local law.

*To Avert a Serious Threat to Health or Safety.* The Plan may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

*To Facilitate Claims Under Employer Plans.* Your health information may be disclosed to another health plan maintained by the Employer for purposes of paying claims under that plan. In addition, medical information may be disclosed to the Employer to administer benefits under the Plan, such as to determine a claims appeal.

*Provide You With Information.* The Plan or its agents may contact you to remind you about appointments or provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

*Organ and Tissue Donation.* If you are an organ donor, the Plan may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplants, or to an organ donation bank to help with organ or tissue donation.

*Military and Veterans.* If you are a member of the armed forces, the Plan may release PHI about you as required by military command authorities. The Plan may also release PHI about foreign military personnel to the appropriate foreign military authority.

*Workers' Compensation.* The Plan may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

*Public Health Risks.* The Plan may disclose PHI about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or to notify the appropriate government authority if the Plan believes a participant has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

*Health Oversight Activities.* The Plan may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

*Lawsuits and Disputes.* If you are involved in a lawsuit or a dispute, the Plan may disclose PHI about you in response to a court or administrative order. The Plan may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

*Law Enforcement.* The Plan may release PHI if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, the Plan is unable to obtain the person's agreement; about a death the Plan believes may be the result of criminal conduct; about criminal conduct at the hospital; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

*Coroners, Medical Examiners and Funeral Directors.* The Plan may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release PHI about you to funeral directors as necessary to carry out their duties.

*National Security and Intelligence Activities.* The Plan may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

*Inmates.* If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release PHI about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

You have the following rights regarding PHI the Plan maintains about you:

*Right to Inspect and Copy.* You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. If you request a copy of the information, the Plan may charge a fee for the cost of copying, mailing, or other supplies associated with your request. The Plan may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

*Right to Amend.* If you feel that medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request.

*Right to an Accounting of Disclosures.* You have the right to request an “accounting of disclosures” where such disclosure was made for any purpose other than treatment, payment, or health care operations. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2004. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

*Right to Request Restrictions.* You have the right to request a restriction or limitation on the medical information the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. The Plan is not required to agree to your request however.

*Right to Request Confidential Communications.* You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail. The Plan will not ask you the reason for your request. The Plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

You will not be retaliated against for exercising the privacy rights described above.

Other uses and disclosures of medical information not covered by the above discussion or the laws that apply to the Plan will be made only with your written authorization. If you provide the Plan permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that the Plan is unable to take back any disclosures the Plan has already made with your permission, and that the Plan is required to retain its records of the benefits that the Plan provided to you.

## **HIPAA SECURITY RULES APPLICABLE TO HEALTH COVERAGE UNDER THE PLAN**

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 (electronic protected health information) that the Employer creates, receives, maintains or transmits on behalf of the Plan, except as stated below.

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 Rule. 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. 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. The Employer will report to the Plan any security incident of which it becomes aware.

The terms of this section shall not apply if ePHI is disclosed to the Employer pursuant to an authorization which meets the requirements of the HIPAA Privacy Rule, 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 section shall not apply if the ePHI disclosed to the Employer is information concerning whether an individual is participating in the Plan.

## **SECTION 8** **PLAN ADMINISTRATION**

### **RESPONSIBILITIES FOR PLAN ADMINISTRATION**

The Plan is administered by the Director of Employee Benefits, who has been appointed by the Employer to act as the Plan Administrator under the Plan, and as such will be named fiduciary of the Plan. The Plan Administrator has the power and authority to manage the operation and administration of the Plan and to take all actions it deems necessary to carry out the provisions of the Plan. The Plan Administrator has the sole and absolute discretion to interpret the provisions of the Plan, make findings of fact, determine the eligibility, rights and status of participants and others under the Plan, and resolve disputes under the Plan. To the extent permitted by law, such interpretations, findings, determinations, and decisions shall be final and conclusive on all persons for all purposes of this Plan. The Plan document, which is the legal document that governs the Plan, is available for review and inspection during regular office hours at the address indicated in the Plan Information section of this document.

### **AMENDMENT OR TERMINATION OF THE PLAN**

The Employer has established this Plan with the bona fide intention and expectation that it will be continued indefinitely, but has no obligation whatsoever to maintain this Plan for any given length of time.

The Employer, as the Plan Sponsor, reserves the right to amend or terminate the Plan at any time for any reason, and may do so retroactively, with or without prior notice to Participants or Beneficiaries. Any such action will be taken only after careful consideration, and shall be by a written instrument duly adopted by the Employer or any of its delegates. Therefore, there is no guarantee that you will be eligible for the benefits described in this document for the duration of your employment.

Upon termination of this Plan, all elections and reductions in compensation relating to the Plan will terminate. However, neither amendment or termination of this Plan will diminish or eliminate any claim for any benefit to which you may have become entitled prior to the amendment or termination, unless necessary in order for the Plan to comply with the law.

## **SECTION 9** **MISCELLANEOUS PROVISIONS**

### **NO GUARANTEE OF EMPLOYMENT**

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

### **QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)**

A “qualified medical child support order” (“QMCSO”) is any court judgment, decree, or administrative order (including a court’s approval of a domestic relations settlement agreement) that either creates or recognizes the right of an alternate recipient—or assigns to the alternate recipient the right—to receive benefits for which a Participant or other Dependent is entitled under this Plan. An “alternate recipient” is any child of a Participant or Spouse who is recognized under a medical child support order as being entitled to enrollment in the Plan.

A QMCSO must include: (1) the name and last known mailing address of the Participant; (2) the name and address of each alternate recipient; (3) a reasonable description of the type of coverage to be provided by this Plan or the manner in which such coverage is to be determined; (4) the period of which coverage must be provided; and (5) each plan to which the order applies.

A QMCSO cannot require the Plan to provide any type or form of benefit, or any option, that it is not already offered except as necessary to meet the requirements of a state medical child support law enacted under the Social Security Act. See the Plan’s QMCSO procedures for more information.

### **NEWBORN'S AND MOTHERS' HEALTH PROTECTION ACT**

To the extent that any Component Benefit Plan provides health benefits in connection with childbirth, please note that group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

### **WOMEN'S HEALTH AND CANCER RIGHTS ACT**

For any Component Benefit Plan that offers mastectomy coverage, such group health plans, insurance companies and health maintenance organizations (HMOs) must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce symmetry, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. Any applicable co-payments and/or co-insurance provisions will still apply.

## **MENTAL HEALTH PARITY ACT**

Pursuant to federal law, if a Component Benefit Plan provides coverage for mental health benefits, such group health plan, insurance company or HMO may not set annual or lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical and surgical benefits. If a health plan imposes no annual or lifetime dollar limit on medical and surgical benefits, such health plan may not impose an annual or lifetime dollar limit on mental health benefits. The above provisions shall also extend to substance use disorder benefits.

For example, a group health plan that includes medical/surgical benefits and substance use disorder benefits must ensure that the financial requirements and treatment limitations that apply to substance use disorder benefits are no more restrictive than those that apply to substantially all medical/surgical benefits. Specifically, the group health plan may not impose separate cost-sharing requirements (such as separate deductibles, co-pays or co-insurance) or treatment limitations (such as providing out-of-network coverage for medical/surgical benefits without providing the same out-of-network coverage for mental health or substance abuse disorder benefits) on mental health or substance use disorder benefits as opposed to those provided for medical/surgical benefits.

## **SECTION 10 STATEMENT OF ERISA RIGHTS**

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

### **Receive Information About Your Plan and Benefits**

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including 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 (EBSA).
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (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. The Plan Administrator is required by law to furnish each participant with a copy of the Summary Annual Report.

### **COBRA and HIPAA Rights**

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be

provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### **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.

### **Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500) from the Plan and do not receive them within 30 days, you may file suit in 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, for each day after 30 days that you did not receive the materials, until you receive the materials, unless the requested materials were not sent because of reasons beyond the control of the 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. No action at law or in equity may be brought to recover under this Plan document until the appeal rights herein provided have been exercised and the Plan benefits requested in such appeal have been denied in whole or in part. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Questions**

If you have 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 (EBSA), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW., 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.

## **SECTION 11** **GENERAL PLAN INFORMATION**

**Plan Name:**

St. John's University Welfare benefit Plan

**Plan Number:**

502

**Plan Sponsor and Plan Administrator:**

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

Administration duties have been delegated to the Director of Employee Benefits, who can be contacted at the address and phone number above.

**Plan Sponsor's Employer Identification No. (EIN):**

11-1630830

**Plan Year:**

The Plan's fiscal records are kept on a Plan Year basis beginning on January 1 and ending on the following last day of December.

**Agent for Service of Legal Process:**

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

**Type of Plan:**

This Plan is a welfare benefit plan providing for medical, dental, vision, long term care, life, AD&D, business travel accident, long-term disability, and prepaid legal services as well as the pre-tax payment of medical and dental premiums and reimbursement of eligible Health Care Expenses.

**Type of Administration:**

The Plan utilizes a Contract Administrator to administer the payment of all some medical and all Health Care Reimbursement Account claims. However, all correspondence related to eligibility, enrollment or continuation coverage should be sent to the Plan Administrator at the address above.

All other benefits under the Plan are fully-insured and administered by the applicable insurance company.

**Type of Funding:**

The Plan has fully-insured contracts with select insurance carriers, which means all claims for reimbursement are paid by the Insurer. The Plan also has self-insured contracts for some medical and all Health Care Reimbursement Account claims, which means that claims for reimbursement are paid from the general assets of the Employee. Premiums for the plan coverage are funded with both Employer and Employee Contributions, and to the extent applicable, may be paid by Employees on a pre- or post-tax

basis. Any such Employee cost-sharing provisions will be provided in a separate document by the Employer.

**Grandfathered Plan Status:**

The medical plan options offered under this Plan are not grandfathered under the Patient Protection and Affordable Care Act (the Affordable Care Act).

## **APPENDIX A FOR 2014**

### Component Benefit Plans Included in This Plan

The following Component Benefit Plans have been incorporated into this Plan as of January 1, 2014:

- Medical Insurance
  - Self-funded Point of Service (POS) option administered by Oxford  
Oxford Health Plans  
PO Box 7082  
Bridgeport, CT 06601-7082  
Phone: 800-444-6222
  - Empire HMO, Policy #386151-D2  
Empire/Blue Cross Blue Shield  
One Liberty Plaza  
New York, NY 10006
  - Emblem HMO, Policy #1004571 000  
Emblem Health/Health Insurance Plan of NY  
55 Water St.  
New York, NY 10041-8190
  - Aetna NY HMO, Policy #006640  
Aetna Health, Inc.  
151 Farmington Ave.  
Hartford, CT 06156-3061
  - Aetna NJ HMO, Policy #006640  
Aetna Health, Inc.  
P.O. Box 1445  
Blue Bell, PA 19422
- Dental Insurance  
UMR
- Life Insurance  
First Reliance
- Accidental Death and Dismemberment Insurance  
First Reliance
- Long-Term Disability Insurance  
First Reliance
- Prepaid Legal Insurance
- Business Travel Accident Insurance

- St. John's University Flexible Spending Account and Premium Only Plan
  - Pre-Tax premium payment of medical and dental insurance premiums
  - Self-funded Health Care Reimbursement Account administered by P&A Group:  
P & A Group  
17 Court Street, Suite 500  
Buffalo, NY 14202-3204  
Phone (877) 855-7105
- Employee Assistance Plan

## **APPENDIX A FOR 2015**

### Component Benefit Plans Included in This Plan

The following Component Benefit Plans have been incorporated into this Plan as of January 1, 2015:

- Medical Insurance
  - Self-funded Point of Service (POS) option administered by Oxford Oxford Health Plans  
PO Box 7082  
Bridgeport, CT 06601-7082  
Phone: 800-444-6222
- Dental Insurance
  - CIGNA  
Routing B2CAU  
900 Cottage Grove Road  
Hartford, CT 06152  
866-226-2785
- Life Insurance
  - The Standard Life Insurance Company  
420 Lexington Ave., Suite 810  
New York, NY 10170  
212-850-5519
- Accidental Death and Dismemberment Insurance
  - The Standard Life Insurance Company  
420 Lexington Ave., Suite 810  
New York, NY 10170  
212-850-5519
- Long-Term Disability Insurance
  - The Standard Life Insurance Company  
420 Lexington Ave., Suite 810  
New York, NY 10170  
212-850-5519
- Prepaid Legal Insurance
- Business Travel Accident Insurance
- St. John's University Flexible Spending Account and Premium Only Plan
  - Pre-Tax premium payment of medical and dental insurance premiums

- Self-funded Health Care Reimbursement Account administered by P&A Group:  
P & A Group  
17 Court Street, Suite 500  
Buffalo, NY 14202-3204  
Phone (877) 855-7105
- Employee Assistance Plan

## **APPENDIX B**

### Eligibility Provisions

- MEDICAL INSURANCE – Full-time employees (working 30 hours+/week) are eligible for coverage on the first day of the month coincident with or next following date of hire.
  - With regard to self-funded medical benefits, certain retirees are also eligible for medical insurance:
    - active, full-time staff or administrative employees who, at the time they retire are at least 55 years of age and have a minimum of 10 years of full-time service with the Employer, and the sum of their age and years of service with the Employer totals 75 years or more; or
    - active, full-time faculty employees who, at the time they retire are at least 65 years of age or are granted early retirement benefits pursuant to the applicable collective bargaining agreement.
  - With regard to self-funded medical benefits, certain disabled individuals are also eligible for medical insurance:
    - Participants may continue to participate in the self-funded medical benefits portion of 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).
    - 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.
- DENTAL INSURANCE – Full-time employees (working 30 hours+/week) are eligible for coverage on the first day of the month coincident with or next following date of hire.
  - Certain retirees are also eligible for dental insurance:
    - active, full-time staff or administrative employees who, at the time they retire are at least 55 years of age and have a minimum of 10 years of full-time

service with the Employer, and the sum of their age and years of service with the Employer totals 75 years or more; or

- active, full-time faculty employees who, at the time they retire are at least 65 years of age or are granted early retirement benefits pursuant to the applicable collective bargaining agreement.
- With regard to dental benefits, certain disabled individuals are also eligible for dental insurance:
  - Participants may continue to participate in the dental benefits portion of 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).
  - 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.
- LIFE INSURANCE – Full-time employees (working 30 hours+/week) are eligible for coverage on the first day of the month coincident with or next following date of hire.
  - Certain retirees are also eligible for life insurance:
    - active, full-time staff or administrative employees who, at the time they retire are at least 55 years of age and have a minimum of 10 years of full-time service with the Employer, and the sum of their age and years of service with the Employer totals 75 years or more; or
    - active, full-time faculty employees who, at the time they retire are at least 65 years of age or are granted early retirement benefits pursuant to the applicable collective bargaining agreement.
- ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE - Full-time employees (working 30 hours+/week) are eligible for coverage on the first day of the month coincident with or next following date of hire.

- LONG TERM DISABILITY INSURANCE – Full-time employees (working 30 hours+/week) are eligible for coverage on the one year anniversary of their date of hire.
- PREPAID LEGAL INSURANCE – Full-time employees (working 30 hours+/week) are eligible for coverage on the first day of the month coincident with or next following date of hire.
- BUSINESS TRAVEL ACCIDENT INSURANCE – Full-time employees (working 30 hours+/week) are eligible for coverage on the first day of the month coincident with or next following date of hire.
- HEALTH CARE REIMBURSEMENT ACCOUNT – Full-time employees (working 30 hours+/week) are eligible for coverage on the first day of the month coincident with or next following date of hire.