SUMMARY PLAN DESCRIPTION FOR THE LOYOLA UNIVERSITY MARYLAND HEALTH & WELFARE BENEFIT PLAN

7/1/2013

Introduction

To recognize the contribution made by its employees, Loyola University Maryland (Loyola) provides a variety of welfare benefits to eligible employees and their dependents. This employee benefits document provides descriptions of the benefits offered and serves as the Summary Plan Description (SPD) for the Loyola University Maryland Health & Welfare Benefit Plan. We urge you to carefully read this summary and the benefit guides and insurance certificates incorporated herein by reference.

This SPD is a policy document and not a contract of employment between Loyola and its employees.

The SPD will be updated from time to time as benefits are modified or added, either through issuance of new inserts or a complete reissuance of the document.

The benefits described in this document include:

- Medical/prescription drug coverage
- Dental insurance
- Core vision insurance (Employee only)
- Buy-up vision insurance
- Group term life and accidental death & dismemberment insurance
- Supplemental life insurance, including spouse and dependent children
- Voluntary short-term disability insurance
- Long-term disability insurance
- Employee assistance program
- Health care flexible spending account program

This SPD for the Loyola University Maryland Health & Welfare Benefit Plan includes general plan information and an explanation of your rights as a participant in an ERISA welfare benefit plan.

In the case of any conflict between plan descriptions contained in this SPD (including benefit guides and insurance certificates that have been incorporated by reference) or any oral descriptions of the Plan and the legal plan documents or insurance contracts, the legal plan documents and insurance contracts will govern.

With the exception of programs that provide benefits through insurance contracts, the Plan Administrator has discretionary authority to interpret the Plan, and to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it. All discretionary interpretations and decisions will be applied in a uniform and nondiscriminatory manner to all eligible employees and dependents.

The Plan Administrator may delegate to any other person or organization any of its powers, duties, and responsibilities with respect to the operation and administration of the Plan, including without limitation, the administration of claims, the authority to authorize payment of benefits, determination of entitlement to benefits, amounts of the benefits to be paid, the review of denied or modified claims, and the discretion to decide matters of fact and interpret Plan provisions.

For programs that provide benefits through insurance contracts, the powers, duties and responsibilities described above generally reside with the insurance company, except that the Plan Administrator continues to have the sole and absolute discretion to determine eligibility under the terms of the Plan.

Please contact the Benefits and Wellness Office if you have questions regarding the benefits described in this SPD.

Section 125 Pre-tax Benefits and Change-in-Status Events

The cost of the benefits provided is funded in part by employer contributions (including flex credits) and in part by employee contributions. To the extent permitted by federal law, employee contributions are made on a pre-tax basis through the separate section 125 cafeteria plan. With pre-tax deductions, your share of the cost of coverage is deducted from your salary before FICA and federal income taxes (and generally state income taxes as well) are withheld. This reduces the income that you report for income tax purposes. Flex credits and employee pre-tax contributions are made through a separate Code section 125 cafeteria plan.

Under the terms of the separate section 125 cafeteria plan, you cannot change your benefit elections and related payroll deductions during the plan year unless (1) you, your spouse or your dependent experiences a Change-in-Status Event and the Change-in-Status Event affects your, your spouse's or your dependent's eligibility for coverage under this plan or another employer's plan or (2) you, your spouse or your dependent experiences another allowable situation as described below.

The Change-in-Status events are changes in:

- legal marital status, including marriage, death of spouse, divorce and annulment.
- number of dependents due to birth, death, adoption and placement for adoption.
- employment for you, your spouse or your dependent, including commencement or termination of employment; commencement of or return from an unpaid leave of absence; change of worksite; or change in employment status.
- residence for you, your spouse or your dependent.
- eligibility status of your dependent due to attainment of age, change in student status, or any similar circumstance.

Other allowable situations for which you may request a change in your benefit elections include:

- entitlement to a Special Enrollment Right.
- taking of an unpaid leave under the Family and Medical Leave Act.
- complying with a judgment, decree or order that requires you, a former spouse or another individual to obtain health coverage for a child who is your dependent.
- entitlement to coverage or loss of eligibility for coverage under Medicare or Medicaid for you, your spouse or your dependent.
- an election change under an employer plan, including changes made during an open enrollment period that does not correspond with this plan's open enrollment period. (Not applicable to Health Care Flexible Spending Accounts)

A request for a benefit election change will not be processed unless:

- you contact the Benefits and Wellness Office within 30 days of the Change-in-Status event or other allowable situation to request the change;
- you provide appropriate documentation to support the change requested; and

- the change is permitted under the terms of the applicable plan document or insurance contract.

For birth, adoption or placement for adoption, the change will be effective as of the date of the event. For all other Change-in-Status Events and allowable situations, the change will generally be effective the first day of the month following the date of the event or the date your benefit election change is received and approved by the Benefits and Wellness Office, whichever is later.

If you are dropping health coverage for a spouse or dependent child due to a divorce or loss of dependent eligibility status, please refer to the "General Notice of COBRA Continuation Rights" at the end of this SPD for the procedures that must be followed to notify Loyola and preserve the right to COBRA continuation coverage.

SUMMARY OF BENEFITS

This chart provides a summary of the benefits available under Loyola University Maryland Health & Welfare Benefit Plan. The benefit guides and insurance certificates listed below provide detailed information on the benefits available and are incorporated by reference into this Summary Plan Description. Please use the list below to identify the incorporated documents for the benefits in which you are enrolled.

Benefit	Insurer or Claims Administrator	Title of Benefit Booklet, Guide or Certificate
Medical and Prescription Drug – PPO	CareFirst of Maryland, Inc. d/b/a CareFirst BlueCross BlueShield 10455 Mill Run Circle Owings Mills, Maryland 21117-5559	Preferred Provider Option Evidence of Coverage
Medical and Prescription Drug – HMO	CareFirst of Maryland, Inc. d/b/a CareFirst BlueCross BlueShield 10455 Mill Run Circle Owings Mills, Maryland 21117-5559	BlueChoice Evidence of Coverage
Dental PPO	Metropolitan Life Insurance Company 200 Park Avenue New York, New York 10166	Your Employee Benefit Plan Dental Expense Benefits PPO Dental Plan
Dental Copay Plan	Metropolitan Life Insurance Company 200 Park Avenue New York, New York 10166	Your Benefit Plan Copay Dental Plan
Core Vision	Mid-Atlantic Vision Service Plan, Inc. 3333 Quality Drive Rancho Cordova, CA 95670	Group Vision Care Policy Certificate of Coverage
Vision Buy-up	Mid-Atlantic Vision Service Plan, Inc. 3333 Quality Drive Rancho Cordova, CA 95670	Group Vision Care Policy Certificate of Coverage
Basic Life and Accidental Death & Dismemberment Insurance	Metropolitan Life Insurance Company 200 Park Avenue New York, New York 10166	Your Benefit Plan Basic Life Insurance, Supplemental Life Insurance, Dependent Life Insurance, Accidental Death & Dismemberment Insurance
Supplemental Life Insurance (including coverage for dependents)	Metropolitan Life Insurance Company 200 Park Avenue New York, New York 10166	Your Benefit Plan Basic Life Insurance, Supplemental Life Insurance, Dependent Life Insurance, Accidental Death & Dismemberment Insurance
Voluntary Short-term Disability Insurance with Retirement / Without Retirement	Metropolitan Life Insurance Company 200 Park Avenue New York, New York 10166	Your Benefit Plan All Employees Pension Plan or All Employees Non Pension Plan Rider - Portability
Long-term Disability Insurance with Retirement / Without Retirement	Metropolitan Life Insurance Company 200 Park Avenue New York, New York 10166	Your Benefit Plan All Employees Pension Plan or All Employees Non Pension Plan
Employee Assistance Program	APS Healthcare, Inc. 44 South Broadway, Suite 1200 White Plans, NY 10601	Employee Assistance Program
Health Care Flexible Spending Accounts	HFS Benefits, a TASC Company 4 North Park Drive, Suite 500 Hunt Valley, MD 21030	Flexible Benefits Plan Summary Plan Description

REQUIRED FEDERAL NOTICES

Grandfathered Health Plan: Loyola University Maryland believes the health plan options are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). 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 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.

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 c/o the Benefits and Wellness Office. 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. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Special Enrollment Rights: If you declined enrollment for yourself**,** your spouse or your dependents in the medical plan because of other medical coverage, you may be able to enroll yourself and/or your dependents in this plan, provided that you request enrollment within 30 days after your previous coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents in the medical plan, provided that you request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.

If you or your dependent lose eligibility for coverage under Medicaid or a State child health plan or if you or your dependent become eligible for State-sponsored premium assistance for the medical plan, you may be able to enroll yourself and/or your dependents in this plan if you request enrollment within 60 days of the date of termination of Medicaid or State child health plan coverage or your eligibility for premium assistance.

Creditable Coverage: You should be provided with 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 COBRA, when COBRA coverage ceases, if you request it before you lose coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage from the Plan, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in other coverage.

Newborns' and Mothers' Health Protection Act: 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 as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 as applicable).

Women's Health and Cancer Rights Act of 1998: The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMO's to provide certain benefits for mastectomy patients who elect breast reconstruction.

In the case of a plan participant who is receiving benefits in connection with a mastectomy, coverage will be provided in a manner determined in consultation with the attending physician for:

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

Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those established for other benefits under the plan.

PLAN INFORMATION

Plan Name:	Loyola University Maryland Health & Welfare Benefit Plan
Plan Sponsor:	Loyola University Maryland 4501 North Charles Street Baltimore, MD 21210 410-617-1366
Plan Administrator:	Loyola University Maryland c/o Director of Benefits and Wellness Programs 4501 North Charles Street Baltimore, MD 21210 410-617-1366
Employer Identification Number:	52-0591623
Plan Year:	The Plan Year is the period beginning July 1 and ending June 30. Plan records are kept on a plan year basis.
Plan Number:	510
Agent for Service of Legal Process:	Service of legal process may be made upon the Plan Administrator.
Health Insurance Issuer Information:	Please refer to the Summary of Benefits for the names and addresses of health insurance issuers. CareFirst of Maryland, Inc. is the claims administrator of medical and prescription drug benefits under the Plan. These medical and prescription drug benefits are self-funded obligations of Loyola and are not guaranteed by CareFirst of Maryland, Inc. If the nonguaranteed nature of these medical and prescription drug benefits change, the new information will be communicated to you. Metropolitan Life Insurance Company (MetLife) is the insurer of dental benefits under the Plan. These dental benefits are fully guaranteed under policies of insurance issued by MetLife. If another insurance company replaces this issuer or if the fully guaranteed nature of these dental benefits changes, the new information will be communicated to you. Vision Service Plan (VSP) is the insurer of vision benefits under the Plan. These vision benefits are fully

	guaranteed under policies of insurance issued by VSP. If another insurance company replaces this issuer or if the fully guaranteed nature of these vision benefits changes, the new information will be communicated to you. HFS Benefits is the claims administrator of health care flexible spending account benefits under the Plan. These health care flexible spending account benefits are self-funded obligations of Loyola and are not guaranteed by HFS Benefits.
Eligibility:	Employees working a minimum of 22.5 hours per week on a regular basis are eligible for benefits described in this SPD and incorporated documents as of the first day of the month coinciding with or next following date of employment. Specific eligibility provisions (including dependent eligibility) for benefits offered under the Plan are contained in the benefit guides and insurance certificates that are incorporated by reference into this SPD. An eligible dependent for medical, dental and vision coverage includes a Legally Domiciled Adult (LDA) in accordance with Loyola's written policy. Please contact the Plan Administrator for specific requirements. A person who is not characterized by Loyola as an employee of Loyola, but who is later characterized by a regulatory agency or court as being an employee, will not be eligible for the period during which he or she was not initially characterized as an employee of Loyola.
Participation:	An eligible employee becomes a participant in the Plan by properly completing and submitting an Election Form to Loyola during the period designated by Loyola as the initial enrollment period. For purposes of the Plan, an Election Form may either be a written form or a process (including a computer process) designated by Loyola. If an eligible employee fails to complete an Election Form during the initial enrollment period, the employee will be enrolled in Core Vision, Basic Life and AD&D insurance, Long Term Disability insurance and the Employee Assistance Program. All other benefit elections will be considered waived. After the initial Election Form has been completed, those

	benefit elections will remain in effect for the balance of that Plan Year or until an eligible employee or dependent experiences a Change-in-Status event or other allowable situation (as described elsewhere in this SPD). Loyola will designate an annual open enrollment period during which election changes may be made for the upcoming Plan Year. Loyola may, in its discretion, require all eligible employees to make new benefit elections during the open enrollment period, in which case failure to make a new election may result in a loss of any coverage that requires an employee contribution for that Plan Year. For the health care flexible spending account benefit, a new election is required prior to the beginning of each Plan Year.
Termination of Participation:	In general, benefits under the plan terminate on the date the participant terminates employment, or if earlier, the date on which an employee ceases to qualify as an eligible employee under the Plan or fails to make required contributions to the Plan. Certain benefits may continue until the end of the month in which the participant terminates employment or ceases to qualify as an eligible employee under the Plan. Specific termination provisions (including dependent termination) for the benefits offered under the Plan are contained in the various benefit guides and insurance certificates that are incorporated by reference into this SPD. Except to the extent required by law, participation in the Plan terminates on the day that a plan participant or dependent reports for active duty as a member of the armed forces of any country. Coverage under the Plan may also be terminated for any individual who engages in fraud or who makes a material misrepresentation of fact relating to coverage. For medical coverage that is subject to the Affordable Care Act, a retroactive termination of coverage may only occur if a participant fails to make any required contribution toward the cost of coverage or if an individual engages in fraud with respect to the Plan or makes an intentional misrepresentation of a material fact. In that case, the Plan will provide at least 30 days advance written notice to any person who will be affected by the retroactive termination of coverage.
Coverage Continuation	If a plan participant is on an approved leave of absence, coverage will continue for up to six months under the

	same terms and conditions that apply to active plan participants. The participant will be responsible for continuing to make his share of the premium payments during this six-month period in order to keep the coverage in effect. If an individual fails to return to work after the expiration of six months of approved leave, coverage will be terminated and COBRA will be offered (as applicable).
Type of Funding and Administration:	The Plan is administered by the Plan Administrator. The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan. All actions and determinations of the Plan Administrator shall be final and binding. Certain benefits under the Plan are fully insured under group insurance contracts entered into between Loyola and the insurance carriers. The insurance carriers are responsible for determining eligibility for and amount of any benefits payable under their respective insurance contracts, and for prescribing claims procedures to be followed and claims form to be used. The insurance carriers, and not Loyola, are responsible for paying claims with respect to these programs. Loyola shares responsibility with the insurance carriers for administering these benefits. The insurance carriers are the Named Fiduciaries for benefit claims and are responsible for determining eligibility for and the amount of benefits payable under the Plan and for providing the claims procedures to be followed and the claims forms to be used by eligible individuals pursuant to the Plan. The insurance carriers also have the authority to require eligible individuals to furnish them with information as they determine necessary for the proper administration of the Plan. Please note that participant benefit accounts under the Plan are merely bookkeeping entries. No assets or funds are ever paid to, held in or invested in any separate trust or account, and no interest is paid on or credited to any benefit account. Some benefits are provided through insurance contracts. To the extent that any benefits are not provided through insurance contracts, they are paid

	from the general assets of Loyola. The cost of benefit coverage is based on the premium charged by the insurance company for fully insured benefits and the expected cost of claims plus administrative charges for self-funded benefits. The plan is financed by contributions from Loyola and by participant contributions. Payroll deduction amounts are determined by Loyola. Please refer to the current Loyola enrollment guide for current payroll deductions.
Important Notices:	Loyola reserves the right, in its sole discretion, to amend the Plan, including but not limited to, an increase in employee contributions or reduction in benefits, or to suspend or terminate the Plan, in whole or in part, at any time. If any change is made, benefits for claims incurred after the date of the change will be paid in accordance to the revised Plan procedures or benefits. Should the Plan terminate, all eligible claims incurred prior to the termination date will be paid as determined by the insurance company or Plan Administrator, if submitted within a reasonable amount of time. Any claims incurred after the date of plan termination will not be considered for payment. Changes will be communicated by the Plan. No provision of the Plan or this SPD shall give any employee any right of continued employment with Loyola or shall in any way prohibit changes in the terms of employment of any employee covered by the Plan. The plan is not established pursuant to any collective bargaining or multiple-employer agreement. If you believe you need emergency care, you should not forgo that care because you are uncertain as to whether it will be covered by the Plan. As a condition to receiving benefits under the Plan, participants and dependents agree to transfer to the Plan their rights to make a claim, sue and recover damages when the injury or illness giving rise to the benefits occurs through an act or omission of another person. Alternatively, if a plan participant or dependent receives any recovery, by way of judgment, settlement or otherwise, from another person or business entity, the covered person agrees to reimburse the Plan in first priority for any benefits paid by it. The obligation to reimburse the Plan in full exists regardless of whether the

	judgment or settlement specifically designates the nature of the recovery and regardless of whether the judgment or settlement fully compensates the plan participant or dependent for damages. The Plan's right of full recovery either by subrogation or reimbursement may be from funds the participant or dependent receives or is entitled to receive from the third party, any liability or other insurance coverage of the third party the individual's own uninsured or underinsured motorist insurance or any other amounts that are paid or payable on behalf of the individual. The Plan may enforce its subrogation or reimbursement rights by requiring the participant or dependent to assert a claim to any of the foregoing coverages to which the individual may be entitled. The Plan will not pay attorney fees or costs associated with the covered person's claim without prior express written authorization of the Plan. All Qualified Medical Child Support Orders that provide Plan coverage for "Alternate Recipients" will be honored by the Plan. If you are served with such a court order, please send it to the Benefits & Wellness Office as soon as possible. As required by applicable law, the Plan uses established procedures to determine whether a medical child support order is a Qualified Medical Child Support Order, which is to be honored by the Plan. Upon request to the Plan Administrator, you may receive, without charge, a copy of these procedures. Except as may be required pursuant to a Qualified Medical Child Support Order, no participant, dependent or beneficiary may transfer, assign or pledge any benefit available under the Plan. The group health plan components of this Plan comply with the privacy requirements for Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA). A copy of the Notice of Privacy Practices is available from the Benefits and Wellness Office.

Statement of Your Rights Under ERISA

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

- You can examine, free of charge, at the Plan Administrator's office and at other locations, all of the Plan documents, including insurance contracts, collective bargaining agreements, if any, and copies of all documents that are filed by the Plan (such as detailed annual reports) with the Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- You can obtain copies of all Plan documents governing the operation of the Plan, by writing to the Plan Administrator. You may have to pay a reasonable charge to cover the cost of photocopying.

- In some cases, the law may require the Plan Administrator to provide you with a summary of the Plan's annual financial report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who operate the Plan. These people are called fiduciaries and have a duty to act prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or exercising your rights under ERISA. If your claim for a Plan benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial, and you have the right to obtain copies of documents relating to the decision, without charge and have the Plan review and reconsider your claim, all within certain time frames.

Under ERISA, there are steps you can take to enforce the preceding rights. For instance, if you make a written request for materials 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 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied after review and reconsideration by the Plan or is ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof considering the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse Plan funds, if any, or if you are discriminated against for asserting your rights, you make 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.

You may have the right to continued health coverage for yourself, spouse or dependents if there is a loss of coverage as a result of a qualifying event. You or your dependents may have to pay for such coverage. You should review this Summary Plan Description and the documents governing the Plan on the rules governing COBRA continuation coverage.

If you have any questions about the Plan, you should contact the Plan Administrator c/o the Benefits and Wellness Office. If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

If you have further questions regarding the Plan or this Summary Plan Description, please contact the Plan Administrator, c/o the Benefits and Wellness Office. Copies of all Plan documents are on file with the Plan Administrator and, upon request, are available to participants and their beneficiaries for examination during regular business hours.

Procedures for Claim Review & Appeal

In order to receive Plan benefits, a claimant must follow the procedures established by the Plan Administrator or the insurance company which has the responsibility for making the particular benefit payment. If the benefits books or guides mentioned in the Summary of Benefits do not describe a claims procedure, then the following claims procedure will apply. If a claimant does not follow the Plan's claims procedures, the claimant may lose the right to a benefit under the Plan, including any right to file a legal action for benefits.

Initial claims for Plan benefits are made to the Plan Administrator or the insurance company (referred to below as reviewer). All claims must be submitted in writing (except to the extent oral claims are permitted for urgent claims as described below).

Claim for a Benefit other than a Health or Disability Benefit

In the case of a claim for a benefit other than a health or disability benefit, the claimant will be notified in writing whether the claim is allowed or denied, in whole or in part, usually within 90 days after filing the claim. If, due to special circumstances, the reviewer needs additional time for a decision, the claimant will be notified in writing, before the end of the 90-day period, of those special circumstances and of when the reviewer expects to make its decision. Under no circumstances may the reviewer extend the time for making its decision beyond 180 days after receiving a claim.

If, within 90 days after filing a claim, the reviewer does not furnish the claimant with a notice of its decision or a notice that special circumstances require more time for processing the claim, the claimant may act as though the claim has been denied and may request a review of the denial of the claim.

If a claim is initially denied, a request for review of a denied claim must be made in writing to the reviewer within 60 days after receiving notice of the denial. As part of the review procedure, the claimant has the right to review and receive, without charge, pertinent documents, information and records and to submit to the reviewer issues and comments in writing. The reviewer will take into account all comments, documents, records 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 decision upon review will be made within 60 days after receipt of request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after receipt of a request for review. The reviewer will give the claimant a written notice of its decision, the specific reasons for the decision and the relevant Plan provisions or insurance contract provision on which the decision is based. If the decision is not furnished within that time frame, the claim will be considered denied upon review. The decision of the reviewer will be final and binding upon both parties.

Claim for a Health Benefit

If the claimant's claim is for urgent care health benefits, the reviewer shall notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the reviewer shall notify the claimant as soon as possible, but not later than 24 hours after the receipt of the claim by the Plan, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the claimant. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The reviewer shall notify the claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

A health benefits claim is considered an urgent care claim if the application of the 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 could not be adequately managed without the care or treatment which is the subject of the claim. The Plan shall defer to the attending physician as to whether the claim is for urgent care.

If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments shall constitute an adverse benefit determination. These determinations shall be known as concurrent care decisions. In such a case, the reviewer shall notify the claimant of the adverse benefit determination at a time sufficiently in advance of the reduction of termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before reduction or termination of the benefit.

Any request by a claimant to extend a course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the reviewer shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

In the case of a pre-service health benefit claim, the reviewer shall notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim by the Plan. If, due to special circumstances, the reviewer needs additional time to process a claim, the claimant shall be notified, within 15 days after the Plan) receives the claim, of those circumstances and of when the reviewer expects to make its decision. Under no circumstances may the reviewer extend the time for making its

decision beyond 30 days after receiving the claim. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

In the case of a post-service health benefit claim, the reviewer shall notify the claimant of the Plan's adverse benefit determination within a reasonable period of time, but no later than 30 days after the receipt of the claim. If, due to special circumstances, the reviewer needs additional time to process a claim, the claimant shall be notified, within 30 days after the reviewer receives the claim, of those circumstances and of when the reviewer expects to make a decision. Under no circumstances may the reviewer extend the time for making its decision beyond 45 days after receiving the claim. If such a decision is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. A health benefit claim is considered a post-service claim if it is a request for payment for services which the claimant has already received.

In considering a claim or an appeal, the reviewer has the right to require the claimant to undergo a medical examination or to have an autopsy performed in the case of death, where permitted by law. The reviewer also has the right to review a provider's statement of treatment, study models, pre-and post-operative X-rays, and any additional evidence deemed necessary as evidence on which a claim or appeal under the Plan may be based.

If the reviewer denies a claim, it must provide to the claimant a written or electronic notice that includes:

- a description of the specific reasons for the denial;
- a reference to the Plan provision or insurance contract provision upon which the denial is based;
- a copy of any rule, guideline, protocol or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided without charge upon request by the claimant);
- if the adverse benefit determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment applying the exclusion limit to the claimant's medical circumstances (or a statement that the same will be provided without charge upon request by the claimant);
- a description of any additional information or material that the claimant must provide in order to perfect the claim;
- an explanation of why the additional information or material is needed;
- notice that the claimant has a right to request a review of the claim denial and information on the steps to be taken if the claimant wishes to request a review of a denied claim; and

- a statement of the claimant's right to bring a civil action under ERISA 502(a) following the denial after review of the initial denial.

In the case of an adverse benefit determination concerning a health claim involving urgent care, the information described above may be provided to the claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this section is furnished not later than 3 days after the oral notification.

A claimant whose initial claim for health benefits is denied has 180 days following receipt of a notification of an adverse benefit determination to request a review of the initial determination. Except as provided below for an expedited review of a denied urgent care health claim, a request for review must be submitted to the reviewer in writing. A claimant may request an expedited review of a denied urgent care health claim either orally or in writing and all necessary information, including the Plan's determination on review, will be transmitter between the Plan and the claimant by telephone or other available similarly expeditious method.

An appeal of an adverse benefit determination may be subject to either a one-step appeal process or a two-step appeal process. Please review the underlying benefit guide or insurance certificate for specific information. For health benefits provided through an insurance contract, the insurer has sole discretionary authority to determine eligibility for benefits and to interpret the terms of the insurance policy.

If the two-step appeal process applies and you are not satisfied with the decision, you have 60 days from the date you receive the denial from the first level appeal to ask for a review of the denial of your appeal request.

A review must meet the following requirements:

- the Plan will provide a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.
- the appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination based in whole or in part on medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual.
- the Plan will identify to the claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review, without regard to whether the advice was relied upon in making the benefit review determination.

In the case of urgent care health claims, the reviewer shall notify the claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of the initial adverse determination by the Plan.

In the case of a pre-service health claim, the reviewer shall notify the claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days (for a one-step appeal) or 15 days (for a two-step appeal) after receipt by the Plan of the claimant's request for the review of the initial adverse determination.

In the case of a post-service health claim, the reviewer shall notify the claimant of the Plan's determination on review within a reasonable period of time but in no event later than 60 days (for a one-step appeal) or 30 days (for a two-step appeal) after receipt by the Plan of the claimant's request for review of the initial adverse determination.

Upon completion of its review of an adverse claim determination, the reviewer will give the claimant, in writing or by electronic notification, a notice containing:

- a description of its decision;
- a description of the specific reasons for the decision;
- a reference to the relevant Plan provisions or insurance contract provisions on which its decision is based;
- a statement that the claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the claimant's claim for benefits;
- a statement describing the claimant's right to bring action for judicial review under ERISA section 502(a);
- if an internal rule, guideline, protocol or similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or similar criterion will be provided without charge to the claimant upon request; and
- if the adverse determination on review is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such an explanation will be provided without charge upon request.

<u>Additional Requirements for Non-Grandfathered Plan</u>

For purposes of any medical coverage that is subject to the Patient Protection and Affordable Care Act and is not a grandfathered plan, the additional requirements set forth below will apply.

The Plan will provide the claimant, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim to give the claimant a reasonable opportunity to respond before that

date. Before the Plan issues a final decision on review based on new or additional rationale, the claimant will be provided, free of charge, with the rationale for the Plan's decision as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim to give the claimant a reasonable opportunity to respond before that date.

The Plan or the insurer will comply with the applicable requirements of any external review law that applies under federal or state law, in accordance with the Affordable Care Act.

If Plan fails to strictly adhere to all of the requirements of the claims procedures set forth above, a claimant will be deemed to have exhausted the administrative remedies available under the Plan. The claimant may proceed with initiating an external review or pursue any available remedies under ERISA or state law without completing the internal review process. In addition, if an external reviewer or court rejects the claimant's request for immediate review on the basis of this standard, the claimant must have the opportunity to resubmit the claim to the Plan for completion of the internal appeals process.

However, the strict adherence standard shall not apply in the case of minor compliance errors that are de minimis, non-prejudicial, attributable to good cause or matters beyond the Plan's control, made in the context of an ongoing, good faith exchange of information, and not reflective of a pattern or practice of non-compliance. If the Plan asserts that a compliance error is minor, the Plan must disclose the basis for its determination.

The claims and appeals procedures outlined above relate solely to whether or not benefits under the Plan are available for the treatment or procedure. The physician determines the appropriate or necessary health care service.

Claim for a Disability Benefit

The reviewer will notify the claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim. If, due to special circumstances, the reviewer needs additional time to process a claim, the claimant will be notified within 45 days after the reviewer receives the claim of those special circumstances and of when the reviewer expects to make its decision but not beyond 75 days. If, prior to the end of the extension period, due to special circumstances, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to 105 days, provided the reviewer notifies the claimant of the circumstances requiring the extension and the date as of which the reviewer expects to render a decision. The extension notice will specifically explain the standards on which entitlement to a disability benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed from the claimant to resolve those issues, and the claimant shall have at least 45 days within which to provide the specified information.

If the reviewer denies a claim, it must provide to the claimant, in writing:

- a description of the specific reasons for the denial;
- a reference to the Plan provision or insurance contract provision upon which the denial is based;
- a description of any additional information or material that the claimant must provide in order to perfect the claim;
- an explanation of why the additional information or material is needed;
- notice that the claimant has a right to request a review of the claim denial and information on the steps to be taken if the claimant wishes to request a review of a denied claim;
- a statement of the participant's right to bring a civil action under a federal law called ERISA following any denial on review of the initial denial; and
- a copy of any rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, or a statement that the same will be provided without charge upon request by the claimant.

A claimant whose initial claim for disability benefits is denied has 180 days following receipt of a notification of an adverse benefit determination to request a review of the initial determination. A request for review must be submitted to the reviewer in writing.

A review will meet the following requirements:

- the Plan will provide a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.
- the Plan will identify to the claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review determination, without regard to whether the advice was relied upon in making the review determination.

For disability benefit claims, the decision on review will be made within 45 days after the reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 90 days after receipt of a request for review.

Upon completion of its review of an adverse initial claim determination, the reviewer will give the claimant, in writing or by electronic notification, a notice containing:

- a description of its decision;
- a description of the specific reasons for the decision;
- a reference to any relevant Plan provisions or insurance contract provisions on which its decision is based;
- a statement that the claimant is entitled to receive, upon request and without charge, reasonable access to and copies of, all documents, records, and other information in the Plan's files which is relevant to the claimant's claim for benefits;

- a statement describing the claimant's right to bring an action for judicial review under ERISA section 502(a); and
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to the claimant upon request.

General Information

If the Plan fails to follow the claims procedures described above, a claimant will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

For purposes of the time periods specified above, the period of time during which a benefit determination is required to be made begins when a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a period of time is extended due to a claimant's failure to submit all information necessary for a claim for non-urgent health care benefits or disability benefits, the period for making the determination is frozen from the date the notification requesting the additional information is sent to the claimant until the date the claimant responds, or if earlier, until 45 days from the date the claimant receives (or was reasonably expected to receive) the request for additional information..

With respect to any insured benefit under the Plan, nothing in the Plan's claims procedures will be construed to supersede any provision of applicable state law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

These benefit claims procedures are intended to reflect the Department of Labor's regulations and should be interpreted accordingly. In the event of any conflict between the procedures stated above and the Department of Labor's regulations, the regulations shall control. In addition, any changes in the Department of Labor's regulations shall be deemed to amend these benefit claims procedures as of the effective date of those changes.