

LOYOLA UNIVERSITY MARYLAND
HEALTH & WELFARE BENEFIT PLAN

WRAP SUMMARY PLAN DESCRIPTION

Loyola University Maryland Health & Welfare Benefit Plan

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LOYOLA UNIVERSITY MARYLAND HEALTH & WELFARE BENEFIT PLAN

WRAP SUMMARY PLAN DESCRIPTION

This document, along with the evidence of coverages, certificates, and descriptions, is the summary plan description (“SPD”) for the Loyola University Maryland Health & Welfare Benefit Plan (the “Plan”). These documents describe the Plan as in effect on July 1, 2018. The Plan may be changed from time to time.

For additional information regarding the Plan, contact the Director of Benefits and Wellness Programs at 410-617-1366 or refer to the official Plan documents and insurance contracts. Copies of the documents are available from the Employer on request.

If the terms of this SPD conflict or are otherwise inconsistent with the Plan documents, the Plan documents and insurance contracts shall govern. If the terms of this SPD conflict or are otherwise inconsistent with an applicable evidence of coverage or certificate (“Certificate”), the Certificate shall govern. However, to the extent any information in an applicable Certificate conflicts or is inconsistent with the information contained in the General Plan Information section of this SPD, the General Plan Information section shall control.

The Plan is administered by the Plan Administrator. Except as otherwise provided in a Component Program’s Certificate, the Plan Administrator shall have complete discretion and authority to control and manage the operation and administration of the Plan, interpret the provisions of the Plan, make findings of fact, correct errors, and supply omissions. The Plan Administrator may delegate to any other person or entity any of its powers, duties, and responsibilities with respect to the operation and administration of the Plan and the Component Programs. All decisions and interpretations of the Plan Administrator made in good faith pursuant to the Plan shall be final, conclusive and binding on all persons, subject only to the applicable claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious.

GENERAL PLAN INFORMATION

Type of Plan:	Welfare Benefit Plan, which includes the Component Programs as enumerated in the Loyola University Maryland Health & Welfare Benefit Plan Appendix (the “Appendix”). The Plan is not established pursuant to a collective bargaining agreement or multiple-employer agreement.
Plan Name:	Loyola University Maryland Health & Welfare Benefit Plan
Plan Number:	510
Plan Year:	The Plan Year is the twelve month period ending June 30. Plan records are kept on a Plan year basis.
Plan Sponsor:	Loyola University Maryland (the “Employer”) 4501 North Charles Street Baltimore, MD 21210 410-617-1366
Plan Sponsor’s EIN:	52-0591623

Plan Administrator: Loyola University Maryland
c/o Director of Benefits and Wellness Programs
4501 North Charles Street
Baltimore, MD 21210
410-617-1366

Agent for Service of Legal Process: Loyola University Maryland
4501 North Charles Street
Baltimore, MD 21210
410-617-1366

Service of legal process may also be made upon the Plan Administrator.

Plan Administration: Unless otherwise indicated in the Appendix, Component Programs available under the Plan are administered by Insurers who provide and guarantee the benefits. Certain self-insured Component Programs may be administered by the Plan Administrator (or a third-party administrator as may be designated by the Plan Administrator).

For Component Programs providing for benefits through insurance contracts, responsibility for administration of the Component Program resides with the respective Insurer, which includes administering claims, determining entitlement to and amount of benefits, authorizing payment of benefits, and conducting review of denied and modified claims. An Insurer has discretion to decide matters of fact and interpret Plan provisions as they relate to the Component Program it administers.

The Plan Administrator shall have sole discretion to determine eligibility for any Component Program under the terms of the Plan.

Claims Administrators: Unless otherwise indicated, the named Insurer or Administrator for a Component Program acts as the Claims Administrator for the respective benefits.

FUNDING, ELIGIBILITY AND BENEFITS

Component Programs are fully insured unless otherwise indicated in the Appendix. Fully insured benefits are provided under a group insurance contract entered into between the Insurer and Loyola University Maryland. It is the Insurer that is responsible for paying claims under a fully insured Component Program, not Loyola University Maryland.

Self-insured Component Programs are provided by the Plan Sponsor and it is the Plan Sponsor who guarantees the benefit and is responsible for paying claims under the Component Program. Without regard as to how a third party administrator pays claims on the Plan Sponsor's behalf for a self-insured Component Program, such payments of benefits shall be considered as made by the Plan Sponsor out of its general assets. No assets or funds are ever paid to, held in or invested in any separate trust or account owned by the Plan, and no interest is paid on or credited to any benefit account.

Premiums for Employees and their Dependents are paid in part by the Plan Sponsor out of its general assets and in part by Employee Contributions. Employee portions of the cost of coverage may be paid pre-tax through the employer-sponsored cafeteria plan unless otherwise indicated. The Plan Administrator will inform you of the amount of any required Employee Contribution for each Component Program. The Plan Administrator reserves the right to change the amount of Employee Contributions required for any benefit.

An Employee (and his or her Spouse and Dependents, if applicable) is eligible to participate in the Plan if the Employee satisfies the requirements for eligibility as stated for the specific Component Program in the Appendix. In order

for an Employee to enroll an eligible Spouse or Dependent, the Employee must also enroll in that same coverage under the Plan. Benefits selected under a specific Component Program will become effective as stated under the information for the specific Component Program in the Appendix. An Employee must make any required employee contributions for the coverage selected to remain eligible.

The Plan Administrator may require an Employee to periodically verify the eligibility of the Employee's Spouse and/or Dependents for a Component Program under the Plan in a manner selected by the Plan Administrator, including by request of supporting legal documentation from the Employee. The Plan Administrator will prospectively terminate a Spouse's and/or Dependent's coverage if the Employee fails to provide the requested documentation or the Spouse's and/or Dependent's documentation is unable to be verified by the Plan Administrator, even if the Spouse and/or Dependent would otherwise be eligible for benefits under the respective Component Program.

An individual who is not characterized by the Employer as an Employee of the Employer, but who is later determined by a state court, federal court or regulatory agency as being an Employee of the Employer, will not be eligible for any Component Program for the period during which the individual was not classified as an Employee by the Employer. Eligibility for any Component Program based on a determination of a state court, federal court or regulatory agency that an individual is an Employee shall be prospective in nature only.

For a full summary of benefits that a specific Component Program provides refer to the Certificate for that Component Program which covers the current plan year. Contract and Group numbers are subject to change. General information about each Component Program and the eligibility requirements for each type of coverage are listed in the Appendix.

To the extent required by applicable law under the Affordable Care Act ("ACA"), the number of hours worked to obtain full-time status for group health plan coverage purposes will be determined in accordance with certain measurement rules adopted by the Employer for all Employees. This measurement information is available upon request to the Plan Administrator.

Under ERISA, the Plan Administrator of the group health plan may have fiduciary responsibilities regarding distribution of dividends, demutualization and use of the Medical Loss Ratio rebates from group health insurers. Some or all of any rebate may be an asset of the Plan, which must be used for the benefit of the participants covered by the policy. Participants should contact the Plan Administrator directly for information on how the rebate will be used.

Receipt of this Summary Plan Description does not guarantee the recipient is eligible to participate in the Plan or any Component Program.

The Component Programs as listed in the Appendix shall be treated as comprising the Plan.

ENROLLING IN THE PLAN

The Plan Administrator will establish procedures in accordance with each Component Program for the enrollment of eligible Employees, their Spouses or Dependents, if any, and will communicate these procedures to eligible Employees. The Plan Administrator will establish enrollment processes that must be completed by a prescribed deadline prior to commencement of coverage under the Plan.

For any Employee who does not complete the established enrollment processes by the prescribed deadline, but is otherwise eligible for the Component Program, the Employee will automatically be enrolled in the Component Programs designated as subject to automatic enrollment in the Appendix. No Component Program which is subject to this automatic enrollment provision shall require any Employee Contribution as a condition of enrollment.

HIPAA PRIVACY ISSUES

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires that Covered Entities protect the confidentiality of your private health information ("PHI"). The Plan complies with the privacy requirements for Protected Health Information under HIPAA as applicable to the Plan. The Plan will never retaliate against any individual for exercising any of their rights under HIPAA. The Plan will never require an individual to waive any of their privacy

rights under HIPAA. A complete description of your rights under HIPAA can be found in the Plan's Privacy Notice or, if appropriate, in the privacy notice provided by the Insurer. To obtain a copy of the Insurer's privacy notice, contact the Insurer. Questions or complaints about the privacy of health information should be directed to the Plan Administrator.

SPECIAL ENROLLMENT RIGHTS

If an Employee declines enrollment for themselves, their Spouse or Dependents because of other health insurance or group health plan coverage, an Employee may be able to enroll themselves and their Spouse and Dependents in this plan if an Employee or their Spouse or Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards an Employee's or Spouse's or Dependents' other coverage). However, the Employee must request enrollment within 30 days after an Employee's or their Spouse's or Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if an Employee has a new Spouse or Dependent as a result of marriage, birth, adoption, or placement for adoption, an Employee may be able to enroll themselves and their Spouse and Dependents. However, an Employee must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If an Employee or their Spouse or Dependents are eligible, but not enrolled, in the Group Medical Plan an Employee may enroll when:

- Medicaid or Children's Health Insurance Program ("CHIP") coverage is terminated as a result of loss of eligibility and the Employee requests coverage under a Group Medical Plan listed in the Appendix within 60 days after the termination, or
- An Employee or their Spouse or Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP and the Employee requests coverage under a Group Medical Plan listed in the Appendix within 60 days after eligibility is determined.

The special enrollment rules do not apply to limited scope dental or vision benefits or certain health care flexible spending accounts (*e.g.*, spending accounts that limit benefits to employee salary reduction amounts).

To request special enrollment or obtain more information, contact the Plan Administrator.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A qualified medical child support order ("QMCSO") is an order made pursuant to state domestic relations law by a court or a state agency authorized under state law to issue child support orders which requires a group health plan to provide coverage to a child or children of an Employee. The Plan Administrator shall comply with the terms of any QMCSO it receives, and shall:

- (a) Establish reasonable procedures to determine whether a medical child support order is a QMCSO (these procedures are available, free of charge, to Participants and Beneficiaries upon request to the Plan Administrator);
- (b) Promptly notify the Employee and the child (or child's guardian) of the receipt of any medical child support order, and the group medical plan's procedures for determining whether a medical child support order is a QMCSO; and
- (c) Within a reasonable period of time after receipt of such order, determine whether such order is a QMCSO and notify the Employee and the child of such determination.

STATE MEDICAID PROGRAMS

Eligibility for coverage or enrollment in a State Medicaid Program will not impact an Employee's eligibility or a Spouse's or Dependent's in this Plan. Payment of benefits shall be in accordance with any assignment of rights as required by any State Medicaid Program.

If a Component Program available under this Plan contains provisions regarding coordination of benefits with State Medicaid Programs, the language in the written materials for such Component Program will govern unless the language fails to comply with applicable laws and regulations.

SPECIAL RULES FOR MATERNITY AND INFANT COVERAGE

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 attending provider or physician, 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 the length of stay not in excess of 48 hours or 96 hours, as the case may be.

SPECIAL RULE FOR WOMEN'S HEALTH COVERAGE

The Women's Health and Cancer Rights Act of 1998 requires group health plans, insurance issuers and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (iii) prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other benefits under the plan or coverage. For answers to specific questions regarding your particular health plan's policy, contact the Plan Administrator.

HEALTH COVERAGE DURING FMLA LEAVE

If your Employer has at least 50 employees employed within 75 miles of your worksite and you take an approved unpaid leave of absence that qualifies as family and medical leave under the Family and Medical Leave Act of 1993 (FMLA), you may generally continue to receive group health coverage for yourself and your covered Spouse and Dependents. Coverage will terminate at the end of your FMLA leave period if you do not return from leave, or on the date you give notice that you will not be returning from FMLA leave, and you may then be eligible for COBRA continuation coverage (as described below). To receive group health plan coverage during unpaid FMLA leave, you must continue to pay your share of the premium. You should contact the Plan Administrator to make arrangements for premium payments during unpaid FMLA leave. If you do not continue your group health plan coverage or other types of coverage during unpaid FMLA leave, your coverages will be reinstated when you return from FMLA leave. For additional information about Plan coverage during FMLA leave, contact the Plan Administrator.

Additional family and medical leave rights may apply under state law. Please contact the Plan Administrator for further information.

UNIFORMED SERVICES REEMPLOYMENT RIGHTS

Your right to continued participation in a group health plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Accordingly, if you are absent from work due to a period of active duty in the military you may elect to continue your group health plan coverage. If you are absent for less than 31 days, you will pay the regular employee share of the cost of the health coverage. If the absence is for 31 or more days, the cost of continuation coverage may not exceed 102% of the full cost of your health coverage.

Continuation coverage will terminate on the earlier of:

- The last day of the 24 month period beginning on the first day of military leave, or
- The date you fail to apply for reemployment, as required under USERRA, after returning from military leave.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

Benefits during a period of military leave must be as generous as benefits available to similarly situated employees on other employer-approved leaves of absence (e.g., family and medical leave).

COBRA COVERAGE

Under a federal law called COBRA (“Consolidated Omnibus Budget Reconciliation Act”), group health plans of most employers with 20 or more employees are generally required to offer covered Employees, their covered Spouses and Dependents the opportunity to make separate elections to extend group health coverage temporarily at group rates after coverage under the Plan would otherwise cease. This extension is called COBRA continuation coverage. Evidence of your good health is not required for this extension. Domestic partners should contact the Plan Administrator to discuss eligibility for continuation coverage.

As an Employee covered under the Plan, you may have the right to elect COBRA continuation coverage if you lose health coverage (or premium payments or contributions for health coverage increase) because:

- Your hours of employment are reduced;
- Your employment is terminated for reasons other than gross misconduct; or
- The Employer starts bankruptcy proceedings under Title XI, if you are a retired employee.

Your Spouse may elect continuation health coverage if he or she loses health coverage (or premium payments or contributions for health coverage increase) under the Plan because:

- Your employment is terminated for reasons other than gross misconduct, or your hours of employment are reduced;
- You die;
- You divorce or become legally separated;
- You become enrolled in Medicare (Part A or B); or
- The Employer starts bankruptcy proceedings under Title XI, and you are retired.

Your dependent child may continue health coverage if he or she loses health coverage (or premium payments or contributions for health coverage increase) under the Plan because:

- He or she loses Dependent status under the Plan;
- Your employment is terminated for reasons other than gross misconduct, or your hours of employment are reduced;
- You die;
- You and your Spouse divorce or become legally separated;
- You become enrolled in Medicare (Part A or B); or
- The Employer starts bankruptcy proceedings under Title XI, and you are retired.

A child born to, adopted by, or placed for adoption with the covered Employee during the continuation coverage period may also be entitled to elect COBRA continuation coverage. Such child’s coverage period will be determined according to the date of the qualifying event that gave rise to the covered Employee’s COBRA coverage. You must notify the Plan Administrator within 30 days and provide supporting documentation.

Under COBRA, you (or your Spouse or dependent child, if applicable) must notify the Plan Administrator by filing a Change of Status notice with the Plan Administrator within 60 days after:

- You and your Spouse are divorced or legally separated; or
- One of your children loses Dependent status under the Plan.

You (or your Spouse or dependent child, if applicable) will then be notified of the right to elect continuation health coverage and the cost to do so. The deadline for electing continuation health coverage is 60 days after the date the Plan ceases to cover you or your Spouse or dependent child, or 60 days from the date you, your Spouse, or dependent child are notified of your COBRA election rights, whichever is later.

If you (or your Spouse or dependent children, if applicable) do not elect continuation coverage, your health coverage will stop. If you (or your Spouse or dependent children, if applicable) choose continuation health coverage, the Plan will provide health coverage identical to that available to similarly situated active employees, including the opportunity to choose among options available during an open enrollment period. However, you (or your Spouse or dependent child, if applicable) must pay for this coverage. The COBRA premium will not exceed 102% of the total premium paid by you and your Employer for that level of coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

If the original qualifying event causing the loss of health coverage was the death of the Employee, divorce, legal separation, Medicare entitlement, or loss of "dependent status" of a dependent child under the Plan, then each qualified beneficiary will have the opportunity to elect 36 months of continuation coverage from the date of the qualifying event. If you (or your Spouse or dependent child, if applicable) lose health coverage under the Plan because your employment was terminated or your hours of employment were reduced (and not immediately followed by termination of employment), then the maximum continuation period will be 18 months from the date of the qualifying event. (If coverage is lost at a date later than the date of the qualifying event and the Plan measures the maximum coverage period and notice period from the date of health coverage loss, then the maximum continuation period will be 18 months from the date of health coverage loss.) If during those 18 months, another qualifying event takes place that entitles your Spouse (or dependent child, if applicable) to continuation health coverage, your Spouse's continuation coverage (or dependent child's continuation coverage, if applicable) may be extended by another 18 months. You must make sure that the Plan Administrator/COBRA Administrator is notified of the second qualifying event within 60 days of the second qualifying event. In no event will your Spouse's health continuation coverage (or your dependent child's health continuation coverage, if applicable) extend for more than a total of 36 months from the date of the initial event. If your covered Spouse and/or dependent child lose coverage due to your termination of employment (for reasons other than gross misconduct) or reduction in hours and such loss occurs within 18 months after you enroll in Medicare, then the maximum continuation coverage period for your Spouse and dependent child shall be 36 months from the date you enrolled in Medicare.

Disability is a special issue. If the Social Security Administration determines that you (or your Spouse or dependent child, if applicable) are disabled at any time during the first 60 days of the continuation health coverage period, or in the case of a child born to, adopted by or placed for adoption with a covered Employee during a COBRA coverage period, during the first 60 days after a child's birth, adoption or placement for adoption, then your continuation coverage period as well as your Spouse's and any Dependent's continuation periods may be extended from 18 months to 29 months. The Employer may charge up to 150% of the total premium paid by you and the Employer during this extended period. To qualify, you (or your Spouse or dependent child, if applicable) must notify the Plan Administrator in writing within 60 days of the date of the Social Security Administration determination and during the initial 18 month continuation coverage period. Your written notice must include your name, Social Security Number, and indicate you have continuation coverage under the Plan. If there is a final determination that the qualified beneficiary is no longer disabled, the Plan Administrator must be notified within 30 days of the determination by the qualified beneficiary, and any health coverage extended beyond the maximum that would otherwise apply will be terminated for all qualified beneficiaries.

In certain circumstances, bankruptcy under Title XI of the Employer will entitle you to continuation health coverage. If the qualifying event causing the loss of health coverage was the bankruptcy of the Employer under Title XI, then each covered retired employee will have the opportunity to receive continuation health coverage until the death of the covered retired employee. Covered spouses, surviving spouses and dependents of the covered retired employee will have the opportunity to elect continuation health coverage for a period that will terminate 36 months following the death of the retired employee or upon the death of the qualified beneficiary, whichever is earlier.

Your right to continuation health coverage (or your Spouse's or dependent child's right, if applicable) under COBRA ends if:

- The Employer ceases to provide group health coverage to any of its employees;

- You (or your Spouse or dependent child, if applicable) fail to pay the premium within 30 days after its monthly due date;
- You (or your Spouse or dependent child, if applicable) become covered, after the date of your COBRA election, under another group health plan, including a governmental plan, that does not contain any exclusion or limitation with respect to any preexisting condition of such qualified beneficiary (other than an exclusion or limitation that may be disregarded under the law);
- You (or your Spouse or dependent child, if applicable) become entitled to Medicare after the date of the COBRA election;
- You (or your Spouse or dependent child, if applicable) have extended continuation coverage due to a disability and then you are determined by the Social Security Administration to be no longer disabled;
- The maximum required COBRA continuation period expires; or
- For such cause, such as fraudulent claim submission, that would result in termination of coverage for similarly situated active employees.

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

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.

Additional continuation rights may apply under state law. Please contact the Plan Administrator for further information.

CLAIMS PROCEDURES FOR THE PLAN

Claims for benefits under each Component Program that is either insured or self-insured will be reviewed in accordance with procedures contained in the Certificate for the particular benefit option provided by the Insurer or by the Third Party Administrator specified in the Certificate. In the event that the Certificate does not specify the manner in which claims are to be made, the following procedure will apply. All other general claims or requests should be directed to the Claims Administrator. If a claim under the Plan is denied in whole or in part, the Claims Administrator will notify you or your beneficiary in writing of such denial within 90 days of receipt of the claim. (This period may be extended to 180 days under certain circumstances.) The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after receipt of a notice of denial, you or your beneficiary may submit a written request for reconsideration of the application to the Claims Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Claims Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended to 120 days under certain circumstances.) In this response, the Claims Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Claims Administrator has the exclusive right to interpret the provisions of the Plan. Decisions of the Claims Administrator are final, conclusive and binding.

CLAIMS PROCEDURE FOR BENEFITS BASED ON DISABILITY DETERMINATION

The following claims procedure shall apply specifically to claims made for disability benefits under one or more Plan features, including any rescission of disability coverage under such Plan features with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, rescission means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for such plans, the claims procedure in the other policies, contracts, summary plan

descriptions, or other written materials shall supersede this procedure as long as such other claims procedure complies with Department of Labor Regulations.

Timing of Adverse Benefits Determination

If a claim under the Plan for a benefit based on a determination of disability is denied in whole or in part, you or your beneficiary will receive written notification of the adverse benefit determination within a reasonable period of time, but no later than 45 days after the Claims Administrator's receipt of the claim. The Claims Administrator may extend this period for up to 30 additional days provided the Claims Administrator determines that the extension is necessary due to matters beyond the Claims Administrator's control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date by which the Claims Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Claims Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

The extension notice will explain the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, you must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information. The period from which you are notified of the additional required information to the date you respond is not counted as part of the determination period.

Adverse Benefits Determination Notice

A denial notice will include:

- the specific reason(s) for your adverse benefit determination;
- reference to the specific Plan provision on which the determination is based;
- a description of any additional material or information necessary for you to fix your claim and an explanation of why such material or information is necessary;
- a description of the review procedures, including a statement of your right to bring a lawsuit following an adverse benefit determination on review;
- a discussion of the decision, including, an explanation of the basis for disagreeing with or not following:
 - (i) the views presented by the health care professionals treating you and vocational professionals who evaluated you;
 - (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
 - (iii) a disability determination regarding you presented by you to the Plan made by the Social Security Administration;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. A document, record, or other information will be considered "relevant" to your claim if such document, record, or other information
 - (i) was relied upon in making the benefit determination;
 - (ii) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

- (iii) demonstrates compliance with the administrative processes and safeguards designed to ensure and verify that benefit determinations are made in accordance with governing plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants; or
- (iv) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Appeal Process

If you disagree with a claim determination, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The subject individual's name and the identification number from the ID card, if any.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

In addition, prior to the appeal determination noted below, the Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim as soon as possible and sufficiently in advance of the date on which the appeal determination is required to be provided to give you a reasonable opportunity to respond prior to that date. Before issuing an adverse benefit determination on appeal based on a new or additional rationale, the Claims Administrator will provide you, free of charge, with the rationale; the rationale will be provided as soon as possible and sufficiently in advance of the date on which the appeal determination is required to be provided to give you a reasonable opportunity to respond prior to that date.

Timing of Appeal Determination

You will be notified of the Claims Administrator's decision upon review within a reasonable period of time, but no later than 45 days after the Claims Administrator receives your appeal request. The 45-day period may be extended for an additional 45-day period if the Claims Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time. You will be provided with written notice prior to the expiration of the initial 45-day period. Such notice will state the special circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

Appeal Determination Notice

If denied, your review decision on appeal will include the following:

- the specific reason(s) for the adverse determination;
- reference to the specific Plan provision on which the benefit determination is based;
- a statement that you are entitled to receive, without charge, reasonable access to any document (i) relied on in making the determination, (ii) submitted, considered or generated in the course of making the benefit determination, (iii) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (iv) that constitutes a statement of policy or guidance with respect to the Plan concerning the claim without regard to whether the statement was relied on;

- a statement describing the Plan’s optional appeals procedures, and your right to receive information about such procedures, as well as your right to bring a lawsuit under Section 502(a) of ERISA and any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;
- the following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency;” and
- a discussion of the decision, including, an explanation of the basis for disagreeing with or not following:
 - (i) the views presented by the health care professionals treating you and vocational professionals who evaluated you;
 - (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
 - (iii) a disability determination regarding you presented by you to the Plan made by the Social Security Administration;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

CLAIMS PROCEDURES FOR GROUP HEALTH PLANS

The following claims procedures shall apply specifically to claims made under any group health plan under this Plan. To the extent that these procedures are inconsistent with the claims procedures contained in the policies, contracts, summary plan descriptions or other written materials for the group health plan, the claims procedures in such other policies, contracts, summary plan descriptions, or other written materials shall supersede these procedures as long as such other claims procedures comply with Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

BENEFIT DETERMINATIONS

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30 day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don’t provide the needed information within the 45-day period, your claim will be denied.

Pre-Service Claims

Pre-Service Claims are those claims that require certification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a Pre-Service Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days. After reviewing the revised Pre-Service Claim, the Claims Administrator will notify you of any additional information needed within 15 days, and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed

information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Care Claims

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition could cause severe pain. In these situations:

- you will receive notice of the benefit determination in writing or electronically as soon as possible, but not later than 72 hours after the Claims Administrator receives all necessary information, or such other timeframe as required under federal law, taking into account the seriousness of your condition.
- notice of denial may be oral with a written or electronic confirmation to follow within 3 days.
- if you filed an Urgent Care Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- the Claims Administrator's receipt of the requested information; or
- the end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided as soon as possible, and the Claims Administrator will notify you of the determination within 24 hours after receipt of the claim, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Benefits Determination Notice

A denial notice for a group health plan will include:

- the specific reason(s) for your adverse benefit determination;
- reference to the specific Plan provision on which the determination is based;
- a description of any additional material or information necessary for you to fix your claim and an explanation of why such material or information is necessary;
- a description of the review procedures, including a statement of your right to bring a lawsuit following an adverse benefit determination on review;
- either the specific rule or guideline used in making your benefits determination or a statement that such a rule or guideline was relied upon in making the determination and that a copy of such rule or guideline will be provided free of charge upon request;
- if the adverse benefit determination is based on a medical judgment, either an explanation of such judgment, or a statement that such explanation will be provided to you free of charge upon request; and

- in the case of an Urgent Care Claim, a description of the expedited review process to which you may be entitled.

In addition to the notice standards described above, to the extent required by the Affordable Care Act, all adverse benefit determination notices will include the following: (a) information identifying the claim involved, including the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code, and the corresponding meaning of those codes; (b) the reason or reasons for the adverse benefit determination that includes the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used to deny the claim (for notices of final internal adverse benefit determinations, the description will include a discussion of the decision); (c) a description of available internal appeals and external review processes, including how to initiate an appeal; and (d) contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist individuals with the internal claims and appeals and external review processes.

How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- patient's name.
- plan identification number.
- date(s) of health care service(s).
- provider's name.
- reason(s) you believe the claim should be paid.
- documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

APPEALS DETERMINATIONS

Pre-Service and Post-Service Claim Appeals

You will be provided with written or electronic notification of the decision on your appeal as follows:

For appeals of Pre-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of Post-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with Urgent Care Claims, see "Urgent Care Claim Appeals" below.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision.

Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

Urgent Care Claim Appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- the appeal does not need to be submitted in writing. You or your doctor should call the Claims Administrator as soon as possible.
- the Claims Administrator will provide you with a written or electronic determination as soon as possible, but not later than 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

The Claims Administrator has the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding.

Appeal Determination Notice

If denied, your review decision on appeal will include:

- the specific reason(s) for the adverse determination;
- reference to the specific Plan provision on which the benefit determination is based;
- a statement that you are entitled to receive, without charge, reasonable access to any document (i) relied on in making the determination, (ii) submitted, considered or generated in the course of making the benefit determination, (iii) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (iv) that constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;
- either the specific rule or guideline used in making your benefits determination or a statement that such a rule or guideline was relied upon in making the determination and that a copy of such rule or guideline will be provided free of charge upon request;
- if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the terms of the Plan to your medical condition, or a statement that such explanation will be provided without charge on request;
- a statement describing the Plan's optional appeals procedures, and your right to receive information about such procedures, as well as your right to bring a lawsuit under Section 502(a) of ERISA; and
- the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If you file an internal appeal for medical benefits, you will continue to be covered pending the outcome of the internal appeal. This means that the Plan shall not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

External Review

If you exhaust all internal appeals procedures, have been denied continued coverage for an ongoing course of treatment or have an urgent care claim, you may be entitled to an external review of your claim. Please consult the Plan Administrator or Claims Administrator for further details.

NO ASSIGNMENT OF BENEFITS

No benefit, right or interest of any Participant or Beneficiary under the Plan shall be subject to sale, transfer, or assignment to any third party.

A Plan Participant's authorization for the Plan to pay a Provider is not an assignment of any of the Participant's rights under the Plan to the Provider. A Participant's authorization to pay does not extend to a Provider any legal right under the Plan. This includes a Participant's right to initiate or appeal any claim a Participant may have under the Plan.

The Plan's act of paying benefits to a Provider on a Participant's behalf shall not establish for the Provider any right under the Plan that the Participant may have.

FILING SUIT AGAINST THE PLAN

Any Participant of the Plan must exhaust all possible claim and appeal procedures stated under the terms of the Plan and applicable Certificate before filing suit against the Plan. The Participant must follow this process when 1) seeking recovery of benefits under the Plan, 2) when attempting to enforce the Participant's rights under the terms of the Plan, or 3) when the Participant seeks a clarification of rights to a future benefit under the terms of the Plan.

Any Participant who wishes to file suit against the Plan must do so within one year of all the Participant's rights under the claims and appeals procedures being exhausted.

SUBROGATION/REIMBURSEMENT

If a Covered Individual files a claim for benefits, the cause of which may be the responsibility of a third party, such Covered Individual may be required to reimburse the Plan or Insurer for any benefits the Plan or Insurer paid on their behalf from any recovery received. For example, if a Covered Individual is injured in an automobile accident which is another party's fault, the Covered Individual may have to repay the Plan or Insurer for the medical expenses they paid on the Covered Individual's behalf out of any amount received from that third party, the third party's insurance, the Covered Individual's own insurance, or any other source of payment that is received as payment, settlement, or other compensation for the accident. A Covered Individual must notify the Plan or Insurer of any claim they may have against any third party as soon as they become aware of the claim, a Covered Individual must sign any subrogation/reimbursement agreement requested by the Plan or Insurer, and a Covered Individual must cooperate with the Plan or Insurer in all attempts to collect from the third party. This means that the Plan or Insurer has the right to act on the Covered Individual's behalf in pursuing payment from the third party.

In the event of a subrogation/reimbursement claim, the Plan or Insurer shall be entitled to recover from the Covered Individual 100% of the benefits they paid on the Covered Individual's behalf, without deduction for attorney's fees and costs. The Plan or Insurer's right of reimbursement/subrogation shall not be limited by application of the common fund doctrine, make whole doctrine or any other legal theory. This obligation shall exist no matter how any judgment, settlement or other recovery the Covered Individual receives is classified. In the event the amount the Plan or Insurer paid on the Covered Individual's behalf exceeds the Covered Individual's judgment, settlement or other recovery received, the Plan shall be entitled to be paid the full amount of such judgment, settlement or other recovery received.

Failure by a Covered Individual to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of benefit payments by the Plan or Insurer that would otherwise be due to the Covered Individual under the Plan, until the Covered Individual satisfies their obligation to the Plan.

For additional information about subrogation/reimbursement, contact the Plan Administrator.

PLAN AMENDMENT OR TERMINATION

The Employer expects to maintain the Plan indefinitely but reserves the right to amend or terminate the Plan if the Employer believes the situation so requires. If you have elected to participate in the Plan, you will be notified in writing if there is any significant amendment or if the Plan is terminated. If the Plan is terminated, the Employer will cease deducting contributions from your salary to pay for Component Programs. However, all previous salary deductions will be used to pay for Component Programs that you have elected.

CIRCUMSTANCES THAT MAY CAUSE LOSS OF BENEFITS

The Plan contains numerous restrictions on the type and amount of benefits payable and the circumstances when paid. You should review the benefits booklets and other relevant materials for further information. You may lose coverage under the Plan if the Employer terminates the Plan or amends it to reduce or eliminate your coverage. You may forfeit the right to benefits if, among other things:

- You revoke your election to participate;
- You terminate employment with the Employer;
- You fail to provide verifiable documentation to the Plan Administrator for a Spouse or Dependent;
- You fail to make required contributions;
- You fail to file benefits claims on a timely basis;
- You make fraudulent benefit claims;
- You cease to be an eligible Employee; or
- The Plan terminates.

For medical coverage that is subject to the Affordable Care Act, a retroactive termination of coverage may only occur if you fail to make any required contribution toward the cost of coverage or if you engage in fraud with respect to the Plan or make 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.

RESPONSIBILITY FOR GOODS/SERVICES

The Employer does not guarantee and is not responsible for the nature or quality of the goods or services provided through any health care provider or program because these goods and services are provided by personnel and agencies outside of the control of the Employer.

NO GUARANTEE OF EMPLOYMENT

The Plan is not an employment contract. Nothing contained in this document nor the Certificates gives you the right to be retained in the service of the Employer or interferes with the right of the Employer to discharge you or to terminate your service at any time.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

- ⇒ Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites 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.

- ⇒ Obtain, upon written request to the Plan Administrator, copies of 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 Plan Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, and your Spouse and Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Spouse or 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.

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 from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court in accordance with the terms of the Plan. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court in accordance with the terms of the Plan. 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 in accordance with the terms of the Plan. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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