Pepperdine University
Health & Welfare Plan
Summary Plan Description

(Effective January 1, 2024)

Table of Contents

This summary plan description ("SPD") describes the health and welfare benefits available to eligible employees of **Pepperdine University** (the "University") and their eligible dependents effective as of January 1, 2024. These benefits are governed by the official plan document: the **Pepperdine University Health & Welfare Plan** (the "Plan"). See the *"Administrative Information"* section for Plan document information.

This SPD can help you better understand and use your health and welfare benefits, replaces previous SPDs, and is intended to comply with the disclosure requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). It is to your advantage to read through this SPD, learn how the benefits work, and share this information with your family.

Incorporated Documents
This SPD includes the insurance policies, contracts, certificates of coverage, summary plan descriptions, and summaries of material modifications for the following benefits (as specifically listed in Appendix B):

- Aetna HMO Broad; Policy No. 232487
- Aetna Value Network HMO; Policy No. 232487
- Aetna OAMC HDHP; Policy No. 232487
- Aetna Ascent PPO: Policy No. 232487
- Kaiser Hawaii HMO; Policy No. 18215
- Kaiser HMO; Policy No. 102095
- Health Advocate Employee Assistance Program ("EAP")
- Health Advocate Wellness Coaching
- Delta Dental PPO Benefits; Policy No. 03835
- DeltaCare USA HMO; Policy No. 75781
- Unum Insurance Flex Life & Accidental Death and Dismemberment; Policy No. 911152
- Unum Insurance Long-Term Disability Benefits; Policy No. 911152
- Reliance Standard Business Travel Accident Insurance Benefits; Policy No. SR225018
- VSP Benefits; Policy No. 12289881
- MetLife Legal Benefits; Plan Identification Number: 990/0684

In addition, this SPD includes:

- Enrollment materials, summaries of benefits and coverage, and other general communications identified by the Plan Administrator as containing information about health and welfare benefits under the Plan.

- The pertinent contracts between the University and claims administrators that provide services under the Plan.

The above documents are incorporated into this SPD and serve as the source of specific information relating to your health and welfare benefits. This SPD and the listed documents function as one document to summarize your benefits.

While this SPD and the incorporated documents describe your health and welfare benefits, if there is any inconsistency or discrepancy among the provisions of these documents and the official Plan document, your rights and benefits are determined under the official Plan document for the Plan. In addition, if there is any inconsistency or discrepancy among the provisions of this SPD and the incorporated documents, this SPD will determine your rights and benefits.

Please Note: This SPD does not include any documents or information for the following benefits:

- The reimbursement of expenses for dependent care assistance under a dependent care flexible spending account.

- The reimbursement of health care expenses under a health flexible spending account.

Descriptions of those benefits are in other summary plan descriptions, which you may obtain by contacting the Plan Administrator. See the "*Plan Contacts*" section for contact information.

Cafeteria Plan Benefits
The University's benefit program includes a cafeteria plan that qualifies under Code Section 125. This allows you to pay your premium contributions for medical, dental and vision benefits, when applicable, on a pre-tax basis and to make contributions to a dependent care flexible spending account, health flexible spending account and/or health savings account ton a pre-tax basis. It also requires that the University adhere to Code Section 125 regulations concerning such terms as when you may make changes to your pre-tax elections each year. In addition, this means you may have to make new elections every year for the pre-tax benefits.

For additional information about your health and welfare benefits, you may contact the following:

Contact	Reasons to Access
Plan Administrator Pepperdine University Attn: Human Resources 24255 Pacific Coast Highway Malibu, CA 90263 Telephone: 310-506-4397	■ Verify your eligibility. ■ Review your benefits. ■ Get answers to most questions. ■ Get information about participant contributions.
Claims Administrators **Medical** Aetna Life Insurance Company PO Box 14079 Lexington, KY 40512-4079 Telephone: 833-380-6601 Kaiser P.O. Box 7004 Downey, CA 90242-7004 Telephone: 800-390-3510 Website: www.kp.org Kaiser Hawaii HMO PO BOX 378021 Denver, CO 80237 Telephone: 877-875-3805 **EAP and Wellness Coaching** Health Advocate P.O. Box 30755 Salt Lake City, UT 84130 Telephone: 800-999-9585 Website: www.liveandworkwell.com **Dental** Delta Dental of California (PPO) PO Box 997330 Sacramento, CA 95899-7330 Telephone: 888-335-8227 Website: deltadentalins.com	■ Review your benefits. ■ Locate a participating provider. ■ Obtain a predetermination. ■ Review your rights as a patient. ■ Speak with a claims service representative. ■ Request or download a claim form.

Contact	Reasons to Access
DeltaCare USA (DHMO) P.O. Box 1810 Alpharetta, GA 30023 Telephone: 800-422-4234 Website: deltadentalins.com **Vision** VSP 3333 Quality Drive Rancho Cordova, CA 95670 Telephone: 800-877-7195 Website: www.vsp.com **Flex Life and AD&D, LTD** Unum Telephone: Term Life and AD&D: 800-445-0402 Disability: 800-858-6843 Website: www.unum.com/claims **Business Travel Accident** Reliance Standard Life Insurance Company PO Box 7307 Philadelphia, PA 19101-7307 Telephone: 800-351-7500 Website: www.reliancestandard.com **Prepaid Legal Services** MetLife Legal 1111 Superior Avenue Cleveland, OH 44114-2407 Telephone: 800-821-6400 Website: www.legalplans.com	
COBRA Administrator Benefitfocus Telephone: 833-972-4012	■ Get information about an extension of health benefits under COBRA.

Your Health and Welfare Benefits
Eligible employees of the University and their dependents are eligible for the following health and welfare benefits under the Plan:

- Medical benefits, including a health savings account* (health flexible spending accounts are offered under the Pepperdine University Cafeteria Plan)
- Prescription drug benefits
- Dental benefits
- Vision benefits
- Long-term disability (LTD) benefits
- Life insurance – basic and optional
- Dependent life insurance
- Accidental death and dismemberment (“AD&D”) insurance – basic and optional
- Business travel accident insurance
- Employee assistance program (“EAP”) benefits
- Wellness coaching benefits
- Prepaid legal services benefits

The details of each of these health and welfare benefits are described in the incorporated documents.

*The University facilitates health savings account contributions through the Pepperdine University Cafeteria Plan, but the health savings accounts themselves are not a component benefit under this Plan and are not subject to ERISA.

Cost of Coverage
For most benefits under the Plan, the University pays part of the cost, and you pay part of the cost. Note that, if the University pays the full cost of any benefit, that benefit will be identified in your enrollment materials.

The University determines the amount of your participant contributions prior to each enrollment period and will provide you with this information in your enrollment materials. You may also contact the Plan Administrator to receive information about your participant contributions.

The cost of your benefits depends on the level of coverage you choose under the Plan. Your participant contributions may be deducted from your paycheck on a pre-tax basis or paid with after-tax dollars, as appropriate.

The cost of health coverage does not include your costs for any applicable deductibles, copays, coinsurance, out-of-network charges, or non-covered items.

Federal Tax Implications for Dependent Coverage
Payments for dependent benefits are usually exempt from federal income tax. Generally, if you can claim an individual as a dependent for federal income tax purposes, then the payment for that dependent's benefits will not be taxable to you as income. However, if you enroll an individual in the Plan who does not meet the federal definition of a dependent, the payment may be taxable to you as income.

The University assumes all dependents are tax dependents under the Internal Revenue Code, except domestic partners and their children. You must contact the Plan Administrator if your domestic partner and his or her children are your tax dependents or if you enroll other dependents who are not tax dependents.

If you have questions concerning your specific situation, you should consult your own tax consultant or attorney.

State Tax Implications for Dependent Coverage
If you enroll an individual in the Plan who does not meet the state definition of a dependent in the state in which you reside (for example, domestic partners), the value of that person's coverage may be taxable to you as income for state income tax purposes.

If you have questions concerning your specific situation, you should consult your own tax consultant or attorney.

Participating Provider Networks and Directories
For health benefits, you may obtain the participating provider directories from the claims administrator for a particular benefit, free of charge. See the "*Plan Contacts*" section for contact information.

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

Your Rights Following a Mastectomy
The Plan includes health benefits for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, benefits will be provided in a manner determined in consultation with the attending physician and the patient 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.

■ Treatment of physical complications at all stages of mastectomy, including lymphedema.

Benefits will be subject to the same annual deductibles, copays, and coinsurance provisions that apply for all other medically necessary procedures under the Plan.

You and your eligible dependents are eligible for the health and welfare benefits under the Plan as follows. Please contact the Plan Administrator if you have any questions about your eligibility.

Your Eligibility
Generally, you are eligible for the health and welfare benefits under the Plan if you are classified in the University's payroll and personnel records as one of the following:

- An active, regularly assigned, full-time staff employee, regularly scheduled to work a minimum of 30 hours per week (except where applicable law requires a lesser number of hours).

- An active, regularly assigned staff employee in an approved "9-12 month" position, regularly scheduled to work a minimum of 30 hours per week.

- An active, regularly assigned, full-time faculty member employed under a regular (non-adjunct) faculty contract, serving in at least a three-quarter time appointment (.75 FTE) each academic year.

If you are not otherwise classified as a benefits-eligible employee, you may become a benefits-eligible employee if you are a "full-time employee" as defined under the Patient Protection and Affordable Care Act, as determined by the University in its sole discretion, in accordance with policies and procedures established by the University in compliance with applicable legal requirements.

The following individuals are not eligible to participate in the Plan:

- Leased employees.

- Adjunct faculty.

- Persons who are classified as special status employees or independent contractors because their employment status is temporary, seasonal, or otherwise inconsistent with regular employment.

- Any member of a collective bargaining unit whose agreement with the University does not specifically provide for participation in the Plan.

If you are excluded from the University's definition of an eligible employee, you will not be eligible for benefits under the Plan, even if a court, the Internal Revenue Service ("IRS"), or any other enforcement authority finds that you should be considered an eligible employee.

Dependent Eligibility
Health Benefits
Your dependents are eligible for the same health benefits under the Plan that you choose for yourself and include your:

- Spouse to whom you are legally married, unless your spouse is in active service in the armed forces.

- Domestic partner legally registered with the State of California under AB205.

- Eligible children who have not attained age 26.

- Eligible unmarried children who have attained age 26, who have a physical or mental disability which began prior to attaining age 26, and who are unable to support themselves and are chiefly dependent on you for support and maintenance. The Plan Administrator has the right to require proof of continuing disability.

- Child(ren) for whom health care coverage is required through a qualified medical child support order ("QMCSO").

Your eligible children include your natural children, legally adopted children (or children placed for adoption), stepchildren, and foster children, regardless of their marital, student, residency, or financial dependency status.

In addition, the children of your domestic partner are eligible for health benefits under the Plan in accordance with the eligibility rules described above.

Life Insurance Benefits
Your dependents are eligible for dependent life insurance benefits under the Plan. Please review the incorporated documents for the eligibility provisions for your dependents.

General Provisions
No person may be covered under the Plan as both an employee and as a dependent of an employee. No person may be covered under the Plan as a dependent of more than one employee. In addition, no dependent may be covered under the Plan without the employee also having coverage. If you and your spouse both work for the University, you will generally both be covered separately as employees.

Please Note: The Plan Administrator has the sole right to determine who is eligible for health and welfare benefits under the Plan and may require documentation proving a dependent's status. If you are unable to provide the required documentation, your dependent will not be eligible for benefits under the Plan. In addition, you may be required to reimburse the Plan for any costs associated with covering an individual who is not an eligible dependent, and your, as well as your dependents', coverage may be terminated.

State Eligibility Laws and ERISA
States sometimes pass laws that require employee benefit plans to provide benefits and/or coverage to individuals who otherwise are not eligible. For example, a state might require an employer to provide coverage and benefits to an ex-spouse or a child who exceeds a plan's age requirements and are not eligible for benefits under a plan.

However, ERISA supersedes those state laws, except as they relate to insured benefits. As a result, the University and this Plan only cover the individuals outlined in this SPD and the incorporated documents, unless otherwise stated by the Plan or the incorporated documents for insured benefits.

Enrollment
The Plan Year runs from January 1 through December 31.

Generally, if you enroll within 30 days of the date you satisfy the eligibility requirements under the Plan, you can participate in the Plan effective as of the first day of the month coinciding with or immediately following the date you satisfied the eligibility requirements under the Plan.

You must enroll in the health and welfare benefits using the appropriate enrollment process established and communicated by the Plan Administrator. You will be given this enrollment information when you are initially eligible and again each year during the annual open enrollment period.

If you do not enroll in the Plan when you are first eligible, you will be automatically enrolled in the default benefits that are described in the enrollment materials for the remainder of that Plan Year. If these benefits do not fit your lifestyle, you may change them at the next open enrollment or in the event of an applicable change in status.

Once you enroll in the Plan, you must again enroll in the health and welfare benefits during the annual open enrollment period for the next Plan Year. If you do not enroll in the Plan during the annual open enrollment period, you will be automatically enrolled in the default benefits that are described in the enrollment materials for the next Plan Year.

You will be able to choose from different coverage levels to cover yourself only or you and your dependents. When you enroll your eligible dependents, you will need to provide relevant documentation as requested by the Plan Administrator.

You may be automatically enrolled in certain benefits that are provided by the University at no cost to you. These benefits will be identified in your enrollment materials.

Please Note: You may only enroll during your initial enrollment period or the annual open enrollment period, unless you qualify for a special enrollment period or you have a qualifying life event. See the "*Changing Your Coverage*" section.

Please contact the Plan Administrator or see the incorporated documents for additional enrollment information.

Effective Date of Your Coverage
If you enroll as a newly hired employee, you and your dependents will become covered under the Plan effective as of the first day of the month coinciding with or immediately following the date you satisfy the eligibility requirements under the Plan, but only if you are actively employed on that date. If you are not actively employed on that date due to your health status, your coverage will become effective on the date determined by the Plan Administrator. However, you will not be denied medical coverage under the Plan due to your health status.

If you enroll or make an election change during the annual open enrollment period, coverage for you and your dependents begins on the next January 1.

Qualified Medical Child Support Orders ("QMCSO")
A QMCSO is a judgment from a state court or an order issued through an administrative process under state law that requires a parent to provide health benefits for a child (often because of legal separation or divorce). A QMCSO cannot require the Plan to cover any type or form of benefit not otherwise offered. However, an order may require the Plan to comply with state laws regarding a child's health coverage.

A QMCSO may require health coverage under the Plan for your child even if you are divorced, your ex-spouse has legal custody of the child, and the child is not dependent on you for support. The QMCSO also gives you a special enrollment right to add health coverage outside of any annual open enrollment period restrictions.

If the University receives a valid QMCSO, you may enroll a dependent child for health benefits under the Plan pursuant to the QMCSO's terms. The change you elect takes effect as of the date the QMCSO is processed.

If the University receives a valid QMCSO and you do not enroll the dependent child for health benefits under the Plan pursuant to the QMCSO's terms, the Plan will provide health benefits for your child in accordance with the terms of the QMCSO. The cost of coverage provided pursuant to the QMCSO will be automatically withheld from your pay, subject to any limits set by state or federal law.

Federal law requires that a QMCSO must meet certain form and content requirements to be valid. The University follows certain procedures to determine if a medical child support order is "qualified". You may request, without charge, a copy of the Plan's QMCSO administrative procedures from the Plan Administrator. If you become subject to an order, you will receive a copy of the QMCSO administrative procedures, free of charge, from the Plan Administrator.

As a Rehired Employee
If you terminate your employment and are rehired by the University during the same Plan Year and within 30 days of your prior termination of employment, you will continue to be enrolled in the same pre-tax benefits in which you participated prior to your termination of employment. If you are rehired more than 30 days after your prior termination of employment or during a subsequent Plan Year, you must enroll again in the Plan to receive pre-tax benefits.

Once you enroll in or decline health and welfare benefits under the Plan, your election generally stays in effect for the Plan Year. However, you can make changes to your election during the Plan Year if:

- You have a qualified family status change, a special enrollment right, or other change in circumstance.
- The change affects the eligibility for coverage and benefits under the Plan for either you or your dependents, as determined by the Plan Administrator.
- The modification in your election is due to and consistent with the change, as determined by the Plan Administrator.

Qualified Family Status Changes

A qualified family status change is a specific change in circumstance that affects your eligibility for coverage and benefits under the Plan for either you or your dependents, which is any of the following:

- You get married or divorced, or your marriage is annulled.
- You enter into a newly eligible domestic partnership or terminate your domestic partnership.
- You have a baby, adopt a child, or have a child placed in your care for adoption or legal guardianship, or gain a dependent child as a result of your domestic partnership.
- Your dependent dies.
- Your dependent gains or loses eligibility status.
- You relocate outside the service area.
- You have a change in employment status, such as:
  - Beginning or ending employment (this provision does not apply if rehired within 30 days).
  - Experiencing a strike or a lockout.
  - Commencing or returning from an unpaid leave of absence (this provision does not apply if leave is 30 days or less).
  - Switching from full-time to part-time employment (or vice versa).

HIPAA Special Enrollment Rights

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) gives you additional flexibility in whom you can enroll for the health benefits under the Plan due to marriage, birth, adoption, or placement for adoption:

- Non-enrolled employee: If you are eligible but not enrolled, you can enroll as of the date of the event.

- Non-enrolled spouse: You can enroll your spouse when you marry. In addition, you can enroll your spouse if you acquire a child through birth, adoption, or placement for adoption. However, if you are not enrolled, you must also enroll.

- New dependents: You can enroll your child who becomes your eligible dependent as a result of the event. However, if you are not enrolled, you must also enroll.

CHIP Special Enrollment
You may also be able to enroll yourself and your eligible dependent in health benefits under the Plan pursuant to a special enrollment right created by the Children's Health Insurance Program Reauthorization Act of 2009. If you or your eligible dependent is eligible for, but not enrolled in, health benefits under the Plan, you (and/or your eligible dependent) may enroll for health benefits if either of the following conditions is met:

- You or your eligible dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a state child health plan under Title XXI of that Act and your (or your eligible dependent's) coverage under that plan is terminated as a result of loss of eligibility for such coverage and you request health benefits under this Plan not later than 60 days after the termination of such coverage; or

- You or your eligible dependent becomes eligible for assistance, with respect to health benefits under this Plan, under such Medicaid plan or state child health plan, if you request health benefits under this Plan not later than 60 days after the date you or your eligible dependent is determined to be eligible for such assistance.

Other Changes in Circumstance
Certain other events also permit you to change your coverage during the Plan Year. The change you make must be consistent with the event:

- A QMCSO requires you or another individual to provide health benefits for a dependent.

- You or your dependent becomes eligible for or loses Medicare or Medicaid coverage.

- You elected "no coverage" because you had coverage elsewhere (for example, under a spouse's plan) and that other coverage later ends because of a loss of eligibility, such as a divorce; termination of employment; the other employer stops offering its plan to the eligible class to which you belong; the other employer stops contributing to its plan; or you or your dependent(s) no longer reside, live, or work in the other plan's network service area and no other coverage is available under the other plan.

- Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") coverage from another employer for you or your dependent is exhausted.

- You experience a significant change in cost of benefits or coverage.

- You or your dependent experiences a significant curtailment or loss of coverage, or this Plan adds or improves a benefit option.

- The period of coverage of another plan, for example, your spouse's plan, is different from the University's period of coverage.

- You or your dependent loses coverage under another group health plan sponsored by a governmental or educational institution, including a state children's health insurance program (CHIP), medical care

program of an Indian Tribal government, state health benefits risk pool, or a foreign government group health plan.

- You experience a reduction in hours of service such that you are expected to average less than 30 hours of service per week, but remain eligible for coverage under the Plan. You may prospectively revoke your election of coverage under the Plan for you and your dependents and elect coverage under another group health plan that provides minimum essential coverage. The new election of coverage must take effect no later than the first day of the second month following the month in which you revoke coverage under the Plan.

- You prospectively revoke your election of coverage under the Plan for you and your dependents and elect coverage through the health care exchanges. The new election of coverage must take effect no later than the day immediately following the last day of the Plan coverage that you revoke.

How to Make Changes During the Year

You can report your mid-year change to the Plan Administrator. However, you must complete the appropriate election change process within 30 days (60 days if due to CHIP or Medicaid eligibility) in order to make the change effective. If you do not report your mid-year change and complete the required process within the 30- or 60-day period, as applicable, you will not be able to make changes to your elections until the next annual open enrollment period, unless you again meet one of the conditions for a change during the Plan Year.

Coverage changes generally take effect on the first of the month following date of the qualifying event. For coverage changes due to a marriage, birth, adoption, or placement for adoption, coverage changes are retroactive and take effect on the date of the qualifying event.

Coordination of benefits procedures will be as described in the incorporated documents. To the extent that the incorporated documents do not have any provisions for coordination of benefits, the procedures described below shall govern.

If you or your dependent(s) is covered by more than one health plan (for example, this Plan and your spouse's/domestic partner's plan), you should understand how plans work together to pay for covered services. The coordination of benefits provision is designed to prevent duplicate payments for the same expenses.

You should file all claims with each plan. However, you generally cannot be reimbursed twice for an expense that is covered by both plans. This Plan is not designed to bring you up to 100% reimbursement (unless you have met your out-of-pocket maximum). Claims are coordinated so that you will receive no more than the benefits allowable under the Plan.

Order of Benefit Determination Rules
The primary plan is the plan that determines and provides or pays health benefits without taking into consideration the existence of any other plan. The secondary plan is the plan that determines, and can reduce its benefits, after taking into consideration the health benefits provided or paid by the primary plan.

A plan that does not have a coordination of benefits rule consistent with this section will always be the primary plan. If the plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The plan that covers a person as an employee or retiree shall be the primary plan and the plan that covers that person as a dependent will be the secondary plan.

- For a dependent child whose parents are not divorced or legally separated, the primary plan will be the plan that covers the parent whose birthday falls first in the calendar year.

  - This Plan pays first if your birthday (month/day) comes before your spouse's/domestic partner's in the calendar year (for example, if your birthday is March 1 and your spouse's/domestic partner's birthday is June 1).

  - If you and your spouse/domestic partner have the same birthday, the plan covering you or your spouse/domestic partner longer pays first.

  - If your spouse's/domestic partner's plan does not use the birthday rule, the rules of that plan determine which plan pays first.

- For the dependent of divorced or separated parents, benefits for the dependent will be determined in the following order:

  - First, according to the provisions of a qualified medical child support order ("QMCSO") or other court decree, if the court decree states that one parent is responsible for the child's health benefits and the plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge.

  - Then, the plan of the parent with custody of the child.

- Then, the plan of the spouse of the parent with custody of the child.

- Then, the plan of the noncustodial parent of the child.

- Finally, the plan of the spouse of the noncustodial parent.

■ If none of the above rules determines the order of benefits, the plan that has covered you for the longer period of time will be the primary plan.

Benefits payable under this Plan will be secondary to benefits provided or required by any group or individual automobile, homeowner's, or premises insurance, including medical payments, personal injury protection, or no-fault coverage, regardless of any provision to the contrary in any other policy of insurance.

Effect on Benefits of This Plan
If this Plan is the secondary plan, it will pay the difference between what it normally would pay if there were no coordination (after any deductible or copayment) and what the primary plan pays.

Recovery of Excess Benefits
If the Plan pays for health benefits that should have been paid by the primary plan, the Plan will have the right to recover such payments.

The Plan will have sole discretion to seek such recovery from any person to whom, or for whom, or with respect to whom, such health benefits were provided or such payments were made by any other plan. If the Plan Administrator requests, you must execute and deliver such instruments and documents as the Plan Administrator determines are necessary to secure the right of recovery for the Plan.

Right to Receive and Release Information
The Plan Administrator, without consent or notice to you, may obtain information from and release information to any other plan with respect to you in order to coordinate your health benefits pursuant to this section. You must provide the Plan Administrator with any information it requests in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information (including an Explanation of Benefits ("EOB") paid under the primary plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Leaves of Absence
Generally, benefits coverage continues while you are on an approved paid leave of absence, but you must continue to make employee contributions for your coverage to continue. Contact the Plan Administrator for additional payment details.

Benefits coverage generally does not continue while you are on an unpaid leave of absence. For more information, please contact your human resources representative or the Plan Administrator.

Uniformed Services Employment and Re-Employment Rights Act
The Uniformed Services Employment and Re-employment Rights Act of 1994, as amended ("USERRA"), sets requirements for continuation of health coverage and re-employment in regard to an employee's military leave of absence. These requirements apply to health coverage for you and your dependents.

Continuation of Coverage
For leaves of less than 31 days, health coverage will continue as described above under "*Leaves of Absence*". For leaves of 31 days or more, you may continue health coverage for yourself and your dependents as follows:

- You may continue coverage by paying the required contributions to the University, until the earliest of the following:
  - 24 months from the last day of employment with the University.
  - The day after you fail to return to work.
  - The day the Plan terminates.
- The University may charge you and your dependents up to 102% of the total cost.

Reinstatement of Benefits
If your health coverage ends during the leave of absence because you do not elect coverage under USERRA and you are reemployed by the University, health coverage for you and your dependents may be reinstated if:

- You gave the University advance written or verbal notice of your military service leave.
- The duration of all military leaves while you are employed with the University does not exceed five (5) years.

You and your dependents will be subject to only the balance of a waiting period, if appropriate, that was not yet satisfied before the leave began. However, if an injury or illness occurs or is aggravated during the military leave, full Plan and USERRA limitations will apply.

If your health coverage under this Plan terminates as a result of your eligibility for military health coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

Family and Medical Leave Act
Your health coverage will be continued during a leave of absence under the Family and Medical Leave Act of 1993, as amended ("FMLA"). The Plan Administrator will give you more detailed information about the FMLA. The FMLA allows eligible employees to take a leave for up to a total of 12 work weeks in a 12-month period for one or more of the following reasons:

- The birth of your child and to care for the newborn child.
- The placement of a child with you for adoption or foster care.
- To care for a family member (child, spouse, or parent) with a serious health condition.
- Your own serious health condition that makes you unable to perform the functions of your job.
- Any qualifying exigency arising out of the fact that your spouse, child, or parent is a covered member in the Armed Forces on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation.

If eligible, you may also take leave for up to a total of 26 work weeks in a single 12-month period to care for a covered member of the Armed Forces with a serious injury or illness.

Benefits Coverage While on FMLA Leave
The University will continue your health coverage under the Plan during your FMLA leave just as if you were still employed. The cost of your health coverage during an FMLA leave must be paid, and you must make all required employee contributions in accordance with the agreement reached between you and the University prior to your FMLA leave becoming effective.

A newly acquired dependent is eligible for coverage while your coverage is continued during an FMLA leave.

Continued coverage ends on the earliest date that you:

- Terminate employment.
- Do not make required contributions.
- Exhaust your approved period of FMLA leave and do not return to work from your FMLA leave.

If your employment does not terminate during your FMLA leave, but you do not return to work once your FMLA leave ends, you can choose to continue health coverage under the COBRA continuation rules. See the "*COBRA Continuation Rights*" section for more details.

Reinstatement of Canceled Coverage Following FMLA Leave
Upon your return to your employment following an FMLA leave, any terminated health coverage will be reinstated as of the date of your return. You will not be required to satisfy any waiting period, if appropriate, to the extent that it had been satisfied prior to the start of the FMLA leave.

State Family and Medical Leave Laws
The University's FMLA policy must comply with any state law that provides greater family or medical leave rights than those provided under its FMLA policy. If your leave qualifies under the FMLA and under a state law, you will receive the greater benefit.

If University Changes Benefits

If the University offers new benefits or changes its benefits while you are on an FMLA leave, you are eligible for the new or changed benefits, but your required contributions for these benefits may increase.

Employees
Your coverage under the Plan will cease on the earliest date below:

- The last day of the month in which you cease to be an employee who is eligible for coverage.
- The last day for which you have made any required contribution for the coverage.
- The last day of the month in which your employment terminates.
- The day on which the Plan is terminated.

Dependents of Employees
Coverage for your dependents will cease on the earliest date below:

- The last day of the month in which you cease to be an employee who is eligible for coverage.
- The last day for which you have made any required contribution for the coverage.
- The last day of the month in which your employment terminates.
- The last day of the month in which the dependent ceases to qualify as a dependent.
- The day on which dependent coverage under the Plan is terminated.
- The day on which the Plan is terminated.

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), offers you the opportunity to continue health coverage under the Plan in certain circumstances. For additional information about your rights and obligations under the Plan and under federal law, contact the Plan Administrator.

COBRA continuation coverage is a temporary continuation of health coverage when it otherwise would end because of a "qualifying event". After a qualifying event, COBRA continuation coverage is offered to each "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries if you have health coverage under the Plan on the day before a qualifying event occurs and that health coverage is lost because of the qualifying event. Qualified beneficiaries also include any children born to you or placed for adoption with you while you are covered during the COBRA continuation period.

Please Note: You may have other options available to you when you lose Plan coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

Please Note: Your domestic partner and his/her children, if covered under a health plan option, are not "qualified beneficiaries" under COBRA. However, they are eligible to elect continued health coverage under the Plan that is similar to the following rules for COBRA continuation coverage. If you are enrolled in an HMO, refer to the materials provided by your local Human Resources representative for information on the availability of continued coverage for domestic partners and their children under the HMO.

Qualified Beneficiaries and Qualifying Events

Covered Employee
You are eligible for COBRA continuation coverage if you lose your health coverage under the Plan because of one of the following qualifying events:

- Your hours of employment are reduced.

- Your employment ends for any reason other than your gross misconduct.

Spouse of Covered Employee
Your spouse is eligible for COBRA continuation coverage if he/she loses health coverage under the Plan because of one of the following qualifying events:

- Your hours of employment are reduced.

- Your employment ends for any reason other than your gross misconduct.

- You die.

- You become divorced from your spouse.

■ You enroll in Medicare benefits (under Part A, Part B or both).

Dependent Children
Your dependent children are eligible for COBRA continuation coverage if they lose health coverage under the Plan because of one of the following qualifying events:

■ Your hours of employment are reduced.

■ Your employment ends for any reason other than your gross misconduct.

■ You die.

■ You become divorced from your spouse.

■ Your child loses eligibility for coverage as a "dependent child" under the Plan.

■ You enroll in Medicare benefits (under Part A, Part B or both).

Notification of Qualifying Events
The Plan offers COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. See the *"Plan Contacts"* section for contact information.

When the qualifying event is the end of your employment, the reduction in your work hours, your enrollment in Medicare, or your death, the University will notify the Plan Administrator of the qualifying event.

For other qualifying events (your divorce or a dependent child losing eligibility for coverage as a dependent child) or the occurrence of a second qualifying event, you or the qualified beneficiary must notify the Plan Administrator within 60 days after the later of the date the qualifying event occurs or the day you lose health coverage because of the qualifying event. If you or your qualified beneficiary fails to notify the Plan Administrator within this 60-day period, your dependent will not be entitled to elect COBRA continuation coverage.

How COBRA Continuation Coverage is Offered
After the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage is offered to each qualified beneficiary.

The Plan Administrator provides a COBRA enrollment notice by mail within 14 days after receiving notice of the qualifying event, and each qualified beneficiary has an independent right to elect COBRA continuation coverage.

You may elect COBRA continuation coverage on behalf of your spouse, and parents may elect COBRA continuation coverage on behalf of their children. It is critical that you (or anyone who may become a qualified beneficiary) maintain a current address with the Plan Administrator to ensure that you receive a COBRA enrollment notice following a qualifying event.

You and your eligible dependent(s) have 60 days from the date health coverage ends due to a qualifying event or from the date of your COBRA notice, whichever is later, to elect COBRA continuation coverage. If you fail to elect COBRA continuation coverage within the applicable timeframe, the opportunity to continue coverage under COBRA will be forfeited.

Effective Date of COBRA Continuation Coverage
If elected within the period allowed for the election, your COBRA continuation coverage is effective retroactively to the date your health coverage would otherwise have terminated due to the qualifying event, and you will be charged for COBRA continuation coverage in this retroactive period. However, if you waive COBRA continuation coverage and then revoke the waiver within the 60-day election period, your elected COBRA continuation coverage begins on the date your waiver is revoked.

How Long COBRA Continuation Coverage Lasts
COBRA continuation coverage is a temporary continuation of health coverage. It lasts for up to a total of 36 months when the qualifying event is:

- Your death.

- Your divorce.

- Your dependent child losing eligibility as a dependent child.

COBRA continuation coverage generally lasts for up to a total of 18 months when the qualifying event is the end of your employment or reduction of your work hours. This 18-month period of COBRA continuation coverage can be extended in two ways:

Disability Extension of 18-Month Period of COBRA Continuation Coverage
If a qualified beneficiary in your family is determined by the Social Security Administration to be disabled, and you notify the Plan Administrator in a timely fashion, you and all other qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months, if all of the following conditions are met:

- Your COBRA qualifying event was your termination of employment or reduction in work hours.

- The qualified beneficiary is determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA continuation coverage, and the disability lasts at least until the end of the 18-month period of COBRA continuation coverage.

- A copy of the Notice of Award from the Social Security Administration is provided to the Plan Administrator within 60 days of receipt of the notice and before the end of the initial 18 months of COBRA continuation coverage.

- An increased premium of 150% of the monthly cost of coverage is paid, beginning with the 19th month of COBRA continuation coverage.

Second Qualifying Event Extension of 18-Month Period of COBRA Continuation Coverage
If another qualifying event occurs during the first 18 months of COBRA continuation coverage, your spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator.

This extension may be available to your spouse and any dependent children receiving COBRA continuation coverage if you die, get divorced, or your dependent child is no longer eligible under the Plan as a dependent child, but only if the event would have caused your spouse or dependent child to lose health coverage under the Plan had the first qualifying event not occurred.

Medicare Extension for Your Dependents
If the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B, or both) within the 18 months before the qualifying event, COBRA continuation coverage for your dependents will last up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for 18 months from the date of your termination of employment or reduction in work hours.

What COBRA Continuation Coverage Costs
COBRA participants must pay monthly premiums for coverage. Premiums are based on the full cost per covered person set at the beginning of the Plan Year, plus 2% for administrative costs. Dependents making separate elections are charged the same rate as a single employee. An increased premium of 150% of the cost of coverage must be paid in the case of disability, beginning with the 19th month of COBRA continuation coverage.

Payment is due at enrollment, but there is a 45-day grace period from the date you mail your enrollment form to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s).

Ongoing monthly payments are due on the first of each month, but there is a 30-day grace period (for example, June payment is due June 1, but will be accepted if postmarked by June 30).

General Provisions
If you, your spouse, and/or dependent child(ren) elect COBRA continuation coverage:

- You can keep the same level of health coverage you had as an active employee or choose a lower level of health coverage.

- You or your dependent may change your health coverage:

  - During the annual open enrollment period.

  - If you have a qualified family status change.

  - If you have a change in circumstance recognized by the Internal Revenue Service (“IRS”).

- You may enroll any newly-eligible spouse or child under Plan rules.

When COBRA Continuation Coverage Ends
COBRA continuation coverage ends when the first of the following events occurs:

- The qualified beneficiary reaches the maximum COBRA continuation period. Health coverage for a newly-acquired dependent who has been added for the balance of a COBRA continuation period would end at the same time that your COBRA continuation period ends.

- The qualified beneficiary becomes covered under another medical plan not offered by the University, provided the plan does not have a legally valid pre-existing condition exclusion or limitation affecting the qualified beneficiary. If it does, COBRA continuation coverage for that pre-existing condition continues as long as you pay your contributions.

- The qualified beneficiary fails to make contributions by the due date as required.

- The University stops providing any health benefits to any employee.

- The qualified beneficiary becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.

- The qualified beneficiary dies.

- Any reason the Plan would terminate health coverage of a participant or beneficiary who is not receiving COBRA continuation coverage (such as fraud).

- The Social Security Administration determines that the qualified beneficiary is no longer disabled (if entitled to 29 months of COBRA continuation coverage under the special disability rule), in which case the extended portion of the COBRA continuation coverage will end with the month that begins more than 30 days after the Social Security Administration's determination.

If You Have Questions
See the "*Your Rights Under ERISA*" section for contact information if you have questions about your rights under COBRA.

Cal-COBRA

At the conclusion of COBRA continuation coverage, Cal-COBRA provides additional continuation coverage for medical benefits in certain situations. See the Plan Administrator for details.

How to File a Claim
The incorporated documents describe how to file a claim for benefits under the Plan. If you have any questions about filing a claim for benefits, you may obtain information from the appropriate claims administrator. See the "*Plan Contacts*" section for contact information.

Eligibility or Benefit Claims
There are two types of claims:

- Eligibility and enrollment claims – A claim to participate or enroll in the Plan or a benefit option or to change an election to participate mid-Plan Year.

- Benefit claims – A claim for a specific benefit, which typically includes your initial request for benefits.

Determination of Eligibility and Enrollment Claims
All claims regarding your eligibility and enrollment for benefits under the Plan are determined by the Plan Administrator, in its sole discretion.

Benefit Claims and Appeals
All benefit claims and appeals for the health and welfare benefits offered under the Plan are determined by the claims administrators in accordance with the claims and appeals procedures described in the incorporated documents.

To the extent that the incorporated documents do not have any provisions for benefit claims and appeals, the procedures described in Appendix A to this SPD shall govern.

Legal Action
You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the claims and appeals procedures. You may not initiate a legal action against the Plan until you have completed the claims and appeals procedures. In addition, you may not initiate a legal action after one (1) year from the date that you have exhausted the Plan's claims and appeal procedures, unless an applicable state statute of limitations provides for a longer period in which to file.

The HIPAA Privacy Rule applies to “Protected Health Information”, which is defined as any written, oral, or electronic health information that meets the following three requirements:

- The information is created or received by a health care provider, the Plan, or the University.
- The information includes specific identifiers that identify you or could be used to identify you.
- The information relates to one of the following:
  - Providing health care to you.
  - Your past, present, or future physical or mental condition.
  - The past, present, or future payment for your health care.

The Notice of Privacy Practices for the Plan contains a complete explanation of your rights under the HIPAA Privacy Rule. The notice describes how Protected Health Information may be used and disclosed, and how you can get access to that information. The following is a summary of those uses and disclosures of Protected Health Information and your rights with respect to Protected Health Information:

- The Plan may use or disclose your Protected Health Information for purposes of conducting health care operations or paying your health care claims.
- The Plan may use or disclose your Protected Health Information to tell you about treatment alternatives or to provide you with information about other health-related benefits or services that may be of interest to you.
- The Plan may disclose your Protected Health Information to the University, as Plan sponsor, to assist the University in the performance of plan administrative functions; the Plan also may provide summary health information to the University, as Plan sponsor, so that the University may obtain premium bids or modify, amend, or terminate the Plan; summary health information does not directly identify you, but summarizes claims history, claims expenses, or types of claims experienced; finally, the Plan may disclose your enrollment and disenrollment information to the University as Plan sponsor.
- The Plan may disclose your Protected Health Information when required to do so by any federal, state, or local law and when permitted to do so under the circumstances set out in the University’s Notice of Privacy Practices.
- The Plan may disclose your Protected Health Information to a law enforcement official for certain law enforcement purposes; for example, the Plan may disclose your Protected Health Information pursuant to a law requiring the reporting of certain types of wounds or other physical injuries.
- The Plan may disclose your Protected Health Information to health care providers to assist them in connection with their treatment or payment activities; in addition, the Plan may disclose your Protected Health Information to other entities subject to the HIPAA Privacy Rule to assist them with their payment activities or certain of their health care operations; for example, the Plan might disclose your Protected Health Information to a health care provider when needed by the provider to render treatment to you.

- Other than as permitted or required by law, the Plan will not use or disclose your Protected Health Information without your written authorization; if you authorize the Plan to use or disclose your Protected Health Information, you may revoke that authorization in writing at any time; if you revoke the authorization, the Plan no longer will use or disclose your Protected Health Information for the reasons covered by your written authorization; your revocation will not affect any uses or disclosures the Plan already has made prior to the date the Plan receives notice of the revocation.

In general, you have the following rights regarding the Protected Health Information retained by the Plan:

- You have the right to request that the Plan restrict uses and disclosures of your Protected Health Information to carry out payment or health care operations and to satisfy legal requirements.

- You have the right to request that the Plan communicate with you in a certain way if you feel that the disclosure of your Protected Health Information could endanger you.

- You have the right to inspect and obtain a copy of your Protected Health Information.

- If you believe that the Protected Health Information the Plan has about you is inaccurate or incomplete, you have the right to request a correction.

- You have a right to request a list of disclosures made by the Plan of your Protected Health Information, other than those disclosures for which an accounting is not required.

- You have a right to request and receive a paper copy of the Notice of Privacy Practices for the Plan, even if you have received this notice previously or agreed to receive this notice electronically.

For more information regarding these rights and the privacy policies of the Plan, please review the Notice of Privacy Practices for the Plan. The Notice of Privacy Practices for the Plan is available from the Plan Administrator.

This section contains important information about how your health and welfare benefits are administered and funded. It also contains information about your rights and responsibilities as a participant and steps you can take if certain situations arise.

Plan Name/Identification
As indicated in the *"Introduction"* section, the benefits described in this SPD are governed by the official Plan document. This Plan is named the **Pepperdine University Health & Welfare Plan**.

The **Pepperdine University Health & Welfare Plan** is an employer-sponsored welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA") and subject to the reporting and disclosure requirements of this law.

The plan number assigned by the University is **501**.

Plan Information
This SPD includes this document and the incorporated documents listed in the *"Introduction"* section. In addition, you can get information about the Plan and your health and welfare benefits from:

- The official Plan document.

- Amendments to the Plan document.

- Applicable summaries of material modifications ("SMMs") to this SPD.

Plan Employer/Plan Sponsor/Employer Identification Number
The Plan employer/Plan sponsor for the Plan is:

Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263

The employer identification number is 95-1644037.

Plan Administrator
The Plan Administrator for the Plan is:

Pepperdine University
Attn: Human Resources
24255 Pacific Coast Highway
Malibu, CA 90263
Telephone: 310-506-4397

Claims Administrators
The claims administrators for the benefits under the Plan are listed in the *"Plan Contacts"* section.

COBRA Administrator
The COBRA administrator for the health benefits under the Plan is listed in the *"Plan Contacts"* section.

Agent for Service of Legal Process
The agent for service of legal process under the Plan is:

Pepperdine University
Attn: Office of General Counsel
24255 Pacific Coast Highway
Malibu, CA 90263

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

Plan Year
The Plan Year is the 12-month period beginning on January 1 and ending on the following December 31.

Funding and Source of Contributions
The Plan is funded by participant contributions and University contributions. University contributions are made from University assets. Participant contributions may be made on a pre-tax basis or paid with after-tax dollars.

For the fully-insured benefits under the Plan, the University pays an insurance company or other provider a premium, from University assets and participant contributions, for providing coverage under the insured options. Insured benefits are paid by the insurance companies who have entered into contracts with the University or the Plan to provide those benefits.

Benefits other than insured benefits are paid from the general assets of the University. To the extent determined necessary by the Plan Administrator, there may be a special fund or trust from which the benefits are paid or which guarantee the payment of benefits.

Premiums for continuation of health benefits under COBRA are paid for by the qualified beneficiary on an after-tax basis.

The University reserves the right to change the amount of required participant contributions for coverage under the Plan at any time, with or without advance notice to participants.

Claims Administrators and Authority to Review Claims
Your eligibility for benefits is determined by the Plan. The Plan Administrator has full discretionary authority to interpret the terms of the Plan summarized in this SPD and determine your eligibility and benefit claims under the Plan's terms. In some cases, the Plan Administrator has delegated this authority.

The Plan Administrator has delegated its authority to determine benefit claims to the claims administrators listed in the *"Plan Contacts"* section. Benefits under the Plan are paid only if the claims administrator decides, in its discretion, that the claimant is entitled to them. The claims administrator has:

- The authority to make final determinations regarding benefit claims under the Plan.

- The discretionary authority to:

  - Interpret the Plan based on provisions and applicable law and make factual determinations about benefit claims arising under the Plan.

  - Decide the amount, form, and timing of benefits.

- Resolve any other matter under the Plan that is raised by a claimant or that is identified by the claims administrator.

In case of an appeal, the claims administrator's decision is final and binding on all parties to the full extent permitted under applicable law, unless the claimant later proves that the claims administrator's decision was an abuse of administrator discretion.

No Employment Rights or Guarantee of Benefits
All terms of the Plan are legally enforceable. However, neither the Plan nor this SPD constitutes a contract of employment or guarantee of any particular benefit.

Misrepresentation or Fraud
If you or your dependent makes a false or misleading statement that is material to your claim for benefits, the Plan Administrator may offset against future payment any amount paid to you to which you were not entitled. The Plan Administrator has the authority to take any additional action as may be deemed necessary to make the Plan whole, in accordance with the law. The Plan Administrator reserves the right to rescind your coverage under the Plan if you or your dependent performs an act, practice, or omission that constitutes fraud or if you or your dependent makes an intentional misrepresentation of material fact.

Amendment/Termination
Although the University presently intends to continue the Plan, it reserves the right to, at any time, amend or terminate any and all health and welfare benefits under the Plan, to amend or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other term or condition of the Plan, and to terminate the entire Plan, or any part, subject to applicable law. The procedures by which these actions may be taken are contained in the legal Plan document, which is available for inspection and copying from the Plan Administrator.

No consent of any participant is required to amend or terminate the Plan.

Termination of the Plan will have no adverse effect on any benefits to be paid under the Plan for any expenses incurred prior to the date that the Plan terminates. Likewise, any extension of benefits under the Plan due to your or your dependent's total disability which began prior to and has continued beyond the date the Plan terminates will not be affected by the Plan's termination. No extension of benefits or rights will be available solely because the Plan terminates.

University's Right to Use Your Social Security Number for Administration of Benefits
The University will require that you and your dependents provide Social Security numbers at the time of enrollment so that the University can assist its claims administrators in complying with various reporting requirements.

The University retains the right to use your Social Security number for benefit administration purposes, including tax reporting. If a state law restricts the use of Social Security numbers for benefit administration purposes, the University generally takes the position that ERISA preempts such state laws.

Outcome of Covered Services and Supplies
The University is not responsible for, and makes no guarantees concerning, the outcome of the covered services or supplies you receive under the Plan.

Unclaimed Funds
If you fail to file a claim using the Plan's procedures, or you fail to accept or cash a claim reimbursement check within 120 days after the reimbursement check has been issued, and the Plan Administrator has made a reasonable attempt to reimburse you, the funds will be considered unclaimed and will be treated

as Plan forfeitures. However, if you should later renew your written claim for reimbursement of the forfeited amount, the Plan will reimburse that amount to you within 90 days of the renewed claim.

Collective Bargaining Agreements
You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements. A copy of the agreement, if any, will be available for examination upon written request to the Plan Administrator.

Reimbursement
This section applies when you recover damages (by settlement, verdict, or otherwise) for an injury, illness, or other condition, including death. If you have received, or in the future may receive, such a recovery, including a recovery from any insurance carrier, the Plan will not cover either the reasonable value of the services to treat the injury or illness or the treatment of the injury or illness. These benefits are specifically excluded.

If the Plan does advance moneys or provide care for the injury, illness, or other condition, you must promptly send to the Plan the moneys or other property that you receive from any settlement, arbitration award, verdict, insurance proceeds, or monetary recovery from any party for the reasonable value of the health benefits advanced or provided to you by the Plan, regardless of whether or not:

- You have been fully compensated or made whole for your loss.

- You or any other party admits to liability.

- The recovery is itemized or called anything other than a recovery for medical expenses incurred.

If a recovery is made, the Plan has first priority to receive reimbursement for any payments made on your behalf, before payment is made to you or any other party. This reimbursement is required from any recovery you make, including uninsured and underinsured motorist coverage; any no-fault insurance; medical payment coverage (auto, homeowners, or otherwise); Workers' Compensation settlements, compromises, or awards; other group insurance (including student plans); and direct recoveries from liable parties.

In order to secure the Plan's rights when it pays benefits in these situations, you must acknowledge and agree to the following when you accept benefits from the Plan:

- Acknowledge that the Plan has first priority against the proceeds of any such settlement, arbitration award, verdict, or other amounts you receive.

- Acknowledge that any proceeds of settlement or judgment, including your claim to such proceeds held by you or any other person, are being held for the benefit of the Plan.

- Assign to the Plan any benefits you may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement.

- Cooperate with the Plan and its agents, provide relevant information, and take actions that the Plan or its agents reasonably request to assist the Plan in making a full recovery of the value of benefits paid.

- Consent to the Plan's right to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan's rights under this section.

- Consent to the Plan's right to deduct from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

- Agree to not take any action that prejudices the Plan's rights of reimbursement.

The Plan is responsible only for those legal fees and expenses to which it agrees in writing. You cannot incur any expenses on behalf of the Plan in pursuit of the Plan's rights under this section. Specifically, no court costs or attorney's fees can be deducted from the Plan's recovery without the express written consent of the Plan. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right.

In cases of occupational illness or injury, the Plan's recovery rights shall apply to all sums recovered, regardless of whether the illness or injury is deemed compensable under any Workers' Compensation or other coverage. Any award or compromise settlement, including any lump-sum settlement, shall be deemed to include the Plan's interest, and the Plan shall be reimbursed in first priority from any such award or settlement.

The Plan shall recover the full amount of benefits advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary or covered person, whether under comparative negligence or otherwise.

Subrogation
This section applies when another party (including insurance carriers who are financially liable) is, or may be considered, liable for your injury, illness, or other condition, including death, and the Plan has advanced benefits. Subrogation is similar to reimbursement, but allows the Plan to "step into your shoes" and obtain a benefit from a third party who was negligent or responsible for your injury or illness. This occurs when the Plan has to pay a benefit due to your injury, illness, or other condition, but would not have owed the payment if the third party had not caused the problem.

In consideration for the advancement of benefits, the Plan is subrogated to all of your rights against any party liable for your injury, illness, or other condition, including death, or which is or may be liable for the payment for the medical treatment of the injury or occupational illness (including any insurance carrier), to the extent of the value of the health benefits advanced to you under the Plan. The Plan may assert this right independently of you. This right includes, but is not limited to, the covered person's rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners, or otherwise), Workers' Compensation coverage, or other insurance, as well as your rights under the Plan to bring an action to clarify your rights under the Plan. The Plan is not obligated in any way to pursue this right independently or on your behalf, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

You are obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, the subrogation rights of the Plan under this section. In the event that you fail to cooperate with this provision, including executing any documents required herein, the Plan will, in addition to remedies provided elsewhere in the Plan and/or under the law, offset from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Plan's subrogation right is a first priority right and must be satisfied in full prior to any of your or your representative's other claims, regardless of whether you are fully compensated for your damages. The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of your legal representation are borne solely by you.

Right of Recovery
If, for some reason, a benefit is paid that is larger than the amount allowed by the Plan, the Plan has a right to recover the excess amount from the person or agency that received or holds this benefit. This excess amount is subject to a constructive trust in favor of the Plan. The person receiving or holding Plan benefits must produce any instruments or papers necessary to ensure this right of recovery.

Your Rights Under ERISA
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 participant with a copy of this summary annual report.

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 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, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court.

- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

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

Assistance With Your Questions

If you have 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 write to:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, DC 20210

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Appendix A

Claims and Appeals Procedures

The claims and appeals procedures described in this Appendix will apply only to the extent there is no claim and appeals procedure set forth in the applicable incorporated document. The claims and appeals procedures set forth in the applicable incorporated document will govern all claims and appeals related to the benefits covered by such incorporated document.

A claim for health benefits is any request for health benefits made in accordance with these claims procedures. Any other request for benefits, including any communications regarding other types of benefits or regarding health benefits but that are not made in accordance with these claims procedures, will not be treated as a claim for health benefits.

Authorized Representative
You may have an authorized representative act on your behalf with respect to a benefit claim or appeal by notifying the claims administrator in writing. The claims administrator will recognize a court order giving a person authority to submit claims and appeals on your behalf. The claims administrator may also recognize providers as authorized to act on your behalf under its procedures.

In the case of an urgent care claim or appeal, the claims administrator will automatically recognize a health care professional with knowledge of your medical condition (for example, the treating physician) as your authorized representative, unless you give the claims administrator other instructions in writing.

Once you have an authorized representative, the Plan will direct all information, notifications, etc. regarding your claim or appeal to the authorized representative. You will receive copies of all notifications regarding decisions, unless you give the Plan other instructions in writing.

Please Note: Once you have an authorized representative, all references in these claims and appeals procedures to "you" will include your authorized representative, where appropriate. Also note that an assignment for payment does not constitute an appointment of an authorized representative under these claims and appeals procedures.

Types of Claims
There are four types of health claims, each with different time limits.

Pre-Service Claims (Other Than Urgent Care Claims)
This is a claim for benefits under the Plan where the Plan requires that, to receive benefits from the Plan, in whole or in part, you must obtain approval before you receive treatment or care.

Urgent Care Claims
This is a pre-service claim for benefits that, if not decided quickly, could seriously jeopardize your life or health or ability to regain maximum function or would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the benefits that are the subject of the claim.

When the claims administrator receives a pre-service claim, it will decide whether it involves urgent care. A person acting on behalf of the Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, will make this determination. However, if a physician with knowledge of your medical condition tells the claims administrator that your claim involves urgent care, the claims administrator will treat your pre-service claim as an urgent care claim.

Post-Service Claims
A post-service claim is a claim for benefits under the Plan after you have received the benefits. Claims filed one (1) year or more after the date of service will not be paid unless you have proof of timely filing (this 12-month requirement does not apply if you are legally incapacitated).

Concurrent Care Claims
The Plan makes a concurrent care decision when it approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. If you have been approved for an ongoing course of treatment, you will be notified in advance if the approved course of treatment is intended to be terminated or reduced. You will be provided with the notice in sufficient time to allow you the opportunity to appeal the decision and receive a decision on your appeal before the termination or reduction takes effect.

If you would like to extend an ongoing course of treatment that is a claim involving urgent care, a claim for such extension should be filed at least 24 hours before the end of the initially approved period of time or number of treatments.

Notifications
Incorrectly Filed Pre-Service (Including Urgent Care) Claims
If you do not follow the correct procedures for filing a pre-service claim (including an urgent care claim), the claims administrator will notify you as soon as possible, but no later than **five (5) days** after it receives the incorrectly filed pre-service claim and no later than **24 hours** after it receives the incorrectly filed urgent care claim. The notification will describe the proper procedures for filing the claim.

Timing of Initial Claims Determination
You will receive a written decision from the claims administrator regarding your health claim as follows:

Urgent Care Claims: For an urgent care claim, you will receive a decision as soon as possible, taking into account the medical urgency, but no later than **72 hours** after the claims administrator receives your claim, regardless of whether the claim is approved or denied, in whole or in part. If it is determined that additional information is needed to process your claim, you will be notified and told the specific information needed no later than **24 hours** after the claims administrator receives your claim. You will have at least **48 hours** to provide the requested information. You will be notified of a decision as soon as possible, but no later than **48 hours** after the requested information is received or, if earlier, the end of the deadline for providing the requested information. Because of the urgency of these claims, notice of a decision may be given verbally and followed up in writing no later than **three (3) days** after the verbal notice.

Pre-Service Claims and Post-Service Claims: For a pre-service claim, you will receive a decision within a reasonable time appropriate to the medical circumstances, but no later than **15 days** after the claims administrator receives your claim, regardless of whether the claim is approved or denied, in whole or in part.

For a post-service claim, you will receive a decision within a reasonable time, but no later than **30 days** after the claims administrator receives your claim, whether the claim is approved or denied, in whole or in part.

If the claims administrator needs more time to process a pre-service claim or a post-service claim because of matters beyond the Plan's control, it may extend the initial period (15 days for a pre-service claim or 30 days for a post-service claim) for up to an additional **15 days** by notifying you of the extension before the end of the initial period. The extension notice will explain the reason for the extension; the date the decision is expected to be made; and, if the extension is needed because you did not submit information necessary to process your claim, the additional information needed. If you are requested to provide additional information to process your claim, you will have at least **45 days** to provide the information. The days from the date you are sent the extension notice to the due date for the requested information (or, if earlier, the date you respond to the request) are not counted as part of the time period by which the claims administrator must make a decision.

Concurrent Care Claims: For a claim to extend an ongoing course of treatment that is a claim involving urgent care, you will receive a decision as soon as possible, taking into account the medical urgency, but no later than **24 hours** after the claims administrator receives your claim, regardless of whether the claim is approved or denied, in whole or in part, provided you file the claim at least **24 hours** before the end of the initially approved period of time or number of treatments.

Any other request to extend an ongoing course of treatment will be decided according to the applicable time limits for urgent care claims, pre-service claims, and post-service claims.

Notice of Determination

If your claim is approved, the claims administrator will notify you in writing and you will receive an Explanation of Benefits as your notification. If your claim is denied, in whole or in part, the written notice will explain:

- The specific reason(s) for the denial.
- Specific references to the pertinent Plan provisions on which the denial is based.
- A description of any additional information or materials necessary for you to perfect the claim and an explanation of why such material or information is needed.
- Information sufficient to identify your claim.
- A copy of any internal rule, guideline, protocol or other similar criteria relied upon in making the adverse benefit determination (or a statement that this information will be provided free of charge, upon request).
- If the denial is based on a medical necessity or experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances (or a statement that this explanation will be provided free of charge, upon request).
- An explanation of the claims review process and time limits applicable to such process (in the case of an urgent care claim, a description of the expedited review process applicable to such claims), including a statement of your rights to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.
- With respect only to a claim for medical benefits:
  - Information sufficient to identify the claim involved.
  - Notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request.
  - A description of the medical benefit's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal.
  - Contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and the external appeals process.

Any such notice of an adverse benefit determination with respect to a claim for medical benefits will be provided in a culturally and linguistically appropriate manner.

Appeal Procedures
You have the right to file an appeal following any adverse benefit determination, including any rescission of coverage.

Appeal Process
You may file an appeal, in writing, with the claims administrator.

If your claim involves urgent care, you may appeal the claim denial either verbally or in writing. All necessary information, including the appeal determination, will be communicated between you and the claims administrator by telephone, facsimile, or other similar method and followed-up with written communication.

You must make your written appeal to the claims administrator within **180 days** following receipt of an adverse benefit determination. Failure to comply with this important deadline may cause you to forfeit any right to any further review of your claim under these procedures or in a court of law.

Your appeal should include the group name, your name, and your ID number or other identifying information shown on the front of the Explanation of Benefits. The claims administrator may call you to obtain medical records and/or other pertinent information in order to respond to your appeal.

Your appeal must include the following:

- The reasons for the appeal.

- Any written comments, documents, records, or other information supporting your appeal, whether or not submitted in connection with your initial claim.

If requested, you will be given reasonable access to, and copies of, all documents, records, or other information relevant to your claim, free of charge, and the identity of any medical expert consulted in connection with your initial claim (regardless of whether the expert's advice was used to deny your claim).

Upon receipt of your appeal, the claims administrator will make a full and fair review of your claim, taking into account all comments, documents, records, and other information submitted by you (regardless of whether the information was submitted or considered in determining your initial claim). The review will not defer to the claims administrator's prior decision and will not be conducted by the person(s) who made the prior decision or his/her subordinate. If the claims administrator's claim denial was based on medical judgment, the claims administrator will consult with a medical professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was neither consulted in connection with its prior decision nor a subordinate of any such person.

With respect to claims and appeals for medical benefits, to the extent required by applicable law:

- you will be allowed to review your claim file and to present evidence and testimony as part of the internal claims and appeals process;

- the applicable claims administrator will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the medical benefit (or at the direction of the medical benefit) in connection with your appeal as soon as possible and sufficiently in advance of the date on which it

provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date; and

- if the denial of your appeal is based on a new or additional rationale, the applicable claims administrator will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date.

Timing of Determination for Appeal
You will receive a written notice from the claims administrator regarding your appeal as follows:

Urgent Care Claims: For an urgent care claim, you will be notified as soon as possible, taking into account the medical urgency, but no later than **72 hours** after the claims administrator receives your appeal, regardless of whether the claim is approved or denied, in whole or in part. Because of the urgency of these claims, you may receive notice of an appeal determination verbally and followed up in writing no later than **three (3) days** after the verbal notice.

Pre-Service Claims and Post-Service Claims: For a pre-service claim (other than urgent care claims), you will be notified within a reasonable time appropriate to the medical circumstances, but no later than **30 days** after the claims administrator receives your appeal, regardless of whether the appeal is approved or denied, in whole or in part.

For a post-service claim, you will be notified within a reasonable time, but no later than **60 days** after the claims administrator receives your appeal, regardless of whether the appeal is approved or denied, in whole or in part.

Concurrent Care Claims: For a claim to extend an ongoing course of treatment that is a claim involving urgent care, you will be notified as soon as possible, taking into account the medical urgency, but no later than **72 hours** after the claims administrator receives your appeal.

Any other request to extend an ongoing course of treatment will be decided according to the applicable time limits for pre-service claims (no later than **30 days** after the claims administrator receives your appeal) and post-service claims (no later than **60 days** after the claims administrator receives your appeal).

Notice of Determination for Appeal
If your appeal is approved, the claims administrator will notify you in writing. If your appeal is denied, in whole or in part, the written notice will explain:

- The specific reason(s) for the denial.

- Specific references to the pertinent Plan provisions on which the denial is based.

- 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 copy of any internal rule, guideline, protocol or other similar criteria relied upon in making the adverse benefit determination (or a statement that this information will be provided free of charge, upon request).

- If the denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan

to your medical circumstances (or a statement that this explanation will be provided free of charge, upon request).

- A statement of your right to bring a civil action under Section 502(a) of ERISA and any time limits for filing such a civil action.

- 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.”

- With respect only to a claim for medical benefits:

  - Information sufficient to identify the claim involved.

  - Notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request.

  - A description of the medical benefit’s external review procedures, the time limits applicable to such procedures and how to initiate an external appeal.

  - Contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and the external appeals process.

  Any such notice of an adverse benefit determination on review with respect to a claim for medical benefits will be provided in a culturally and linguistically appropriate manner.

Exhaustion of Process
You must exhaust the internal claims and appeals process before you can request an external review or bring any litigation regarding your adverse benefit determination, except in the case of a “deemed exhaustion”. If the Plan fails to adhere to the internal claims and appeals process above, you will be deemed to have exhausted the internal claims and appeals process and may initiate an external review, as discussed below, or pursue available remedies under ERISA. However, if the Plan’s failure to adhere to the internal claims and appeals process is de minimis or for good cause or due to matters beyond the Plan’s control or part of an ongoing, good faith exchange of information between the Plan and you, then there is no “deemed exhaustion”.

External Review Process
You may request external review of any final adverse benefit determination with respect to a claim for medical benefits that qualifies as set forth below. Subject to verification procedures that the claims administrator may establish, your authorized representative may act on your behalf in requesting and pursuing external review.

Requesting external review will have no effect on your rights to any other benefits under the Plan. External review is voluntary, and you are not required to undertake it before pursuing legal action. If you choose not to request external review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

The external review process gives you the opportunity to have a review of the claims administrator's determination on your appeal conducted pursuant to applicable federal law. Your request will be eligible for external review if the following are satisfied:

■ The Plan's internal claims and appeals processes have been exhausted; or

■ The Plan's internal claims and appeals processes are deemed exhausted, as discussed above.

■ Your claim involves a medical judgment or a rescission of coverage.

■ Your claim is not for a denial of coverage based upon your eligibility for Plan participation.

The written notice that you receive regarding the claims administrator's adverse benefit determination on your appeal will describe the process to follow if you wish to request an external review and will include a copy of the Request for External Review form.

You must submit the Request for External Review form to the claims administrator within **four (4) months** after you receive notice of the claims administrator's adverse benefit determination on your appeal. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday. You also must include a copy of the claims administrator's determination and all other pertinent information that supports your request for external review.

If you request external review, any applicable statute of limitations will be tolled while the external review is pending.

Preliminary Review
Within **five (5) business days** after the claims administrator receives your Request for External Review form, it will conduct a preliminary review to determine the following: you were covered under the Plan at the time the benefit was requested or provided, the determination does not relate to eligibility for Plan participation, you have exhausted the internal claims and appeals process (unless "deemed exhaustion" applies), and you have provided all paperwork necessary to complete the external review.

Within **one (1) business day** after completion of the preliminary review, the claims administrator will issue you a written notice of its determination. If the Request for External Review form is complete but not eligible for external review, the notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA [866-444-3272]). If the Request for External Review form is not complete, the notice will describe the information or materials needed to make the request complete, and you will have until the later of the **four (4)-month** filing period, or the **48-hour** period after you receive the notice, to submit the information or materials.

Referral to Independent Review Organization (IRO)
If the claims administrator determines that your request is eligible for external review, the claims administrator will assign an Independent Review Organization ("IRO"), accredited as required under federal law, to conduct the external review. The Plan must contract with at least three (3) IROs for assignments under the Plan and rotate review assignments among them.

The IRO will timely notify you in writing of the request's eligibility and acceptance for external review and will provide an opportunity for you to submit in writing, within **10 business days** following the date of receipt of the notice, additional information that the IRO must consider when conducting the external review. Within **five (5) business days** after the assignment to the IRO, the claims administrator will provide the IRO with all documents and information that the claims administrator considered in making its

decision on your appeal. If the claims administrator fails to provide the documents within the **five (5)-day** period, the IRO may unilaterally terminate external review and make a decision to reverse the claims administrator's adverse benefit determination. If the IRO makes the decision to terminate external review, the IRO will, within **one (1) business day** of making its decision, notify you, the claims administrator, and the Plan.

Upon receipt of any information submitted by you, the IRO must forward that information to the claims administrator within **one (1) business day**. The claims administrator may then reconsider its adverse benefit determination. If the claims administrator decides to reverse its adverse benefit determination, the claims administrator must provide written notice of its decision to you and the IRO within **one (1) business day** after making the decision. The IRO will then terminate the external review.

IRO Decision
The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim and not be bound by any decisions or conclusions reached during the claims administrator's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- Your medical records.
- The attending health care professional's recommendation.
- Reports from appropriate health care professionals and other documents submitted by the Plan, you, or your treating provider.
- The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations.
- Any applicable clinical review criteria developed and used by the claims administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law.
- The opinion of the IRO's clinical reviewer(s) after considering the information described above, to the extent the information or documents are available and the clinical reviewer(s) considers it appropriate.

The IRO will provide written notice of its Final External Review Decision within **45 days** after receiving your Request for External Review form. The IRO will deliver its Final External Review Decision to you, the claims administrator, and the Plan. The IRO's notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (e.g., the date or dates of service, the health care provider, the claim amount, the diagnosis code and its meaning, the treatment code and its meaning, and the reasons for the previous denials).
- The date the IRO received the external review assignment from the claims administrator and the date of the IRO's decision.

- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, that the IRO considered in making its determination.

- A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision, and any evidence-based standards that were relied upon by the IRO in making its decision.

- A statement that the determination is binding, except to the extent that other remedies may be available under state or federal law to either the Plan or you.

- A statement that you may still be eligible to seek judicial review of any adverse external review determination.

- Current contact information, including the telephone number, for any applicable office of health insurance consumer assistance or ombudsmen available to assist you.

If the IRO's Final External Review Decision reverses the claims administrator's adverse benefit determination, the Plan must immediately provide the benefit (including immediately authorizing or immediately paying the claim).

Expedited External Review Process

You may request an expedited external review at the time you receive:

- An initial determination as stated in an Explanation of Benefits ("EOB") involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal.

- An adverse benefit determination on appeal, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the appeal determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Preliminary Review: Immediately upon receipt of your request for expedited external review, the claims administrator will conduct the preliminary review described above for standard external review. The claims administrator will immediately send you a notice of its determination.

Referral to IRO for Expedited Review: If the claims administrator determines that your request for expedited external review is eligible for expedited external review, the claims administrator will assign an IRO. The claims administrator will provide or transmit all necessary documents and information considered in making its initial determination or its adverse benefit determination to the IRO electronically, by telephone, by fax, or by any other available expeditious method. The IRO will review the information and documents described above for standard external review and will provide a decision as expeditiously as your medical condition or circumstances require, but in no event more than **72 hours** after the IRO receives the request for an expedited external review. If the notice is not in writing, within **48 hours** after the date of providing the notice, the IRO will provide written confirmation of the decision to you, the claims administrator, and the Plan.

If the IRO's decision reverses the claims administrator's determination, the claims administrator immediately must provide the benefit (including immediately authorizing or immediately paying the claim).

IRO Records

After its Final External Review Decision, the IRO will maintain records of all claims and notices associated with the external review process for **six (6) years**. An IRO will make such records available for examination by you, the Plan, or the state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Disability claims should be filed as soon as possible following the date of disability.

Notification of Initial Determination
The claims administrator has up to **45 days** to evaluate and process claims for disability benefits. The 45-day period may be extended twice, by **30 days** each, provided the claims administrator determines that an extension is necessary due to matters beyond the control of the claims administrator and notifies you within the initial period (and within the first 30-day extension period, if applicable). The claims administrator must inform you of the circumstances requiring the extension and the date by which the claims administrator expects to render a decision. In addition, the notice of extension must include 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 to resolve those issues. You have at least **45 days** from receipt of the notice to provide the specified information.

An “adverse benefit determination” is a denial, reduction, or termination of a disability benefit or failure to provide or pay for (in whole or in part) a disability benefit. In the event of an adverse benefit determination, you will receive written notice of the determination. This written notification will include:

- The specific reason(s) for the denial.
- Specific references to the pertinent Plan provisions on which the denial is based.
- A description of any additional information or materials necessary to perfect the claim and an explanation of why such material or information is needed.
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by your health care professional or a vocational professional who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in making the benefit determination and (c) any Social Security disability determination you presented to the Plan.
- Either the specific internal rules, guidelines, protocols, standards or similar criteria relied upon in making the adverse determination, or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.
- If the adverse benefit determination is based on medical necessity, 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.
- 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.
- An explanation of the claims review process and the time limits applicable to such process, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

The notice of adverse determination will be provided in a culturally and linguistically appropriate manner.

Filing an Appeal
If your claim is denied in whole or in part, you may appeal the decision by submitting your appeal in writing within **180 days** after you receive the claims administrator's notice of the adverse benefit determination. Failure to comply with this important deadline may cause you to forfeit any right to any further review of your claim under these procedures or in a court of law. The request must be made in writing and should be filed with the claims administrator. In addition, the notice of your adverse benefit determination will specify how to file an appeal.

The review will be conducted by the claims administrator or another appropriately named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal, if medical judgment is involved). Where the denial of your claim is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. The initial adverse determination will not be given favored consideration.

You will have the opportunity to submit written comments, documents, records and other information relating to the claim. You will be provided upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits and the identity of any medical expert consulted in connection with your initial claim (regardless of whether the expert's advice was used to deny your claim). Whether a document, record or other information is relevant to the claim will be determined in accordance with applicable U.S. Department of Labor regulations. The review will take into account all comments, documents, records and other information you may submit relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

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 your appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date. In addition, if the denial of your appeal is based on a new or additional rationale, the claims administrator will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date.

Notification of Appeal Determination
The claims administrator will notify you of the Plan's determination on appeal within a reasonable period of time, but not later than **45 days** after receipt of the written request for review. If special circumstances require an extension of time for processing (up to **45 additional days**), you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to the claims administrator. The 45-day extension of the appeal review period will begin after you have provided that information.

The claims administrator will provide you with written notification of the determination on review. In the case of an adverse benefit determination, such notice will indicate:

■ The specific reason(s) for the denial.

■ Specific references to the pertinent Plan provisions on which the denial is based.

- 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 the claim for benefits.

- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about those procedures.

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by your health care professional or a vocational professional who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in making the benefit determination and (c) any Social Security disability determination you presented to the Plan.

- Either the specific internal rules, guidelines, protocols, standards or similar criteria relied upon in making the adverse determination, or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

- If the adverse benefit determination is based on medical necessity, 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.

- A statement of your right to bring a civil action under Section 502(a) of ERISA and any time limits for filing such a civil action.

- With respect to any applicable contractual limitations period that applies to your right to bring an action under Section 502(a) of ERISA, the calendar date on which the contractual limitations period expires.

A notice of an adverse benefit determination will be provided in a culturally and linguistically appropriate manner.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

Insurance claims should be filed as soon as possible following the date of death or the loss.

If your claim is based on your disability, you must follow the claims procedures specified in the "*Disability Claims and Appeals Procedures*" section.

Notification of Initial Determination
The claims administrator has up to **90 days** to evaluate and process claims for insurance benefits. If more than 90 days is needed to make a decision on a claim, due to matters beyond the control of the claims administrator, you will be notified in writing within the initial 90-day period, and the notice will explain why more time is required. Up to an **additional 90 days**, for a total of 180 days, may then be taken to decide the claim. The extension notice will show the date by which the decision will be sent. If you submit a claim and you do not receive a response within 90 days, you should consider the claim denied.

An "adverse benefit determination" is a denial, reduction, or termination of an insurance benefit or failure to provide or pay for (in whole or in part) an insurance benefit. In the event of an adverse benefit determination, you will receive written notice of the determination. This written notification will include:

- The specific reason(s) for the denial.
- Specific references to the pertinent Plan provisions on which the denial is based.
- A description of any additional information or materials needed to perfect the claim and an explanation of why such material or information is needed.
- An explanation of the claims review process and the time limits applicable to such process, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

If your claim is based on your disability, the claims administrator will make a determination using the procedures specified in the "*Disability Claims and Appeals Procedures*" section.

Filing an Appeal
If your claim is denied in whole or in part, you may appeal the decision by submitting your appeal in writing within **90 days** after you receive the claims administrator's notice of the adverse benefit determination. Failure to comply with this important deadline may cause you to forfeit any right to any further review of your claim under these procedures or in a court of law. The request must be made in writing and should be filed with the claims administrator. In addition, the notice of your adverse benefit determination will specify how to file an appeal. You have the right to:

- Upon request and free of charge, reasonable access to and copies of all relevant documents, records and other information relating to the claim for benefits.
- Submit written comments, documents, records and other information relating to the claim.

Whether a document, record or other information is relevant to the claim will be determined in accordance with applicable U.S. Department of Labor regulations.

The claims administrator will make a full and fair review of the claim and all new information submitted, whether or not presented or available at the initial determination. The claims administrator may require additional documents as it deems necessary or desirable in making such a review.

If your claim is based on your disability, you must follow the appeals procedures specified in the "*Disability Claims and Appeals Procedures*" section.

Notification of Appeal Determination
The claims administrator will notify you of the Plan's determination on appeal within a reasonable period of time, but not later than **60 days** after receipt of the written request for review. If special circumstances require an extension of time for processing (up to **60 additional days**), you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to the claims administrator. The 60-day extension of the appeal review period will begin after you have provided that information.

The claims administrator will provide you with written notification of the determination on review. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason(s) for the denial.
- Specific references to the pertinent Plan provisions on which the denial is based.
- 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 the claim for benefits.
- A statement of your right to bring a civil action under Section 502(a) of ERISA and any time limits for filing such a civil action.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

If your claim is based on your disability, the claims administrator will make an appeal determination using the procedures specified in the "*Disability Claims and Appeals Procedures*" section.

Appendix B

Incorporated Documents

(a) **Group Health Benefits (Medical)**

Aetna HMO Broad; Policy No. 232487
Aetna Value Network HMO; Policy No. 232487
Aetna OAMC HDHP; Policy No. 232487
Aetna Ascent PPO: Policy No. 232487
Kaiser Hawaii HMO; Policy No. 18215
Kaiser HMO; Policy No. 102095

(b) **Employee Assistance Program ("EAP") Benefits**

Health Advocate; EAP Summary Plan Description (SPD)

(c) **Group Dental Benefits**

Delta Dental PPO; Policy No. 03835
DeltaCare USA HMO; Policy No. 75781

(d) **Group Life Insurance Benefits**
Employee Term Life Coverage - Basic and Optional Benefits
Dependent Term Life Coverage

Unum Insurance; Policy No. 911152

(e) **Accidental Death and Dismemberment Insurance Benefits**

Unum Insurance; Policy No. 911152

(f) **Business Travel Accident Insurance Benefits**

Reliance Standard; Policy No. SR225018

(g) **Group Long-Term Disability Insurance Benefits**

Unum Insurance; Policy No. 911152

(i) **Voluntary Vision Benefits**

VSP; Policy No. 12289881

(j) **Legal Benefits**

MetLife; Plan Identification Number: 990/0684