

**VILLANOVA UNIVERSITY
HEALTH AND WELFARE PLAN
AND
SUMMARY PLAN DESCRIPTION**

As of June 1, 2014

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INTRODUCTION

Villanova University (the “University”) maintains the Villanova University Health and Welfare Plan (the “Plan”). This document describes the Plan as in effect as of June 1, 2014.

This document serves two important functions related to the Plan under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), a federal law applying to employee benefit plans:

- First, ERISA requires that employers provide eligible employees with a description of the various benefit plans they maintain. Such information is to be included in a summary plan description (“SPD”) for each plan. This document, together with booklets, certificates and other descriptive material you have received from the University and the insurance companies, constitutes the SPD for the Plan.
- Second, ERISA requires that employee benefit plans be maintained pursuant to a written plan document. This document, together with the contracts entered into between the University and the insurance companies, constitutes the written plan document under ERISA.

IMPORTANT: This description and the booklets, certificates and other descriptive material provided to you by the University and the various benefit providers are written in a manner that is intended to be easily understandable and to summarize the benefits available to you under the Plan. There may be other Plan materials (such as an insurance policy or other contractual agreement with a health care or other service provider) that contain more detailed provisions. Every effort has been made to ensure that all of these materials contain a consistent description of the Plan’s benefits. However, if there is any conflict or inconsistency between these materials, it is the Plan Administrator’s responsibility to interpret the conflicting provisions and determine what benefits will be provided under the Plan. Also, please keep in mind that the Plan, any changes to it, or any payments to you under its terms, does not constitute a contract of employment with the University and does not give you the right to be retained in the employment of the University. No one speaking on behalf of the Plan or the Plan sponsor can alter the terms of the Plan. You and your beneficiaries may obtain copies of the Plan and its related documents or examine these documents by contacting the Plan Administrator at the number and address set forth in the ADDITIONAL INFORMATION section of this document.

This document also addresses certain pre-tax features of the Villanova University Cafeteria Plan. For a more complete description of the pre-tax premium conversion or certain flexible spending accounts that may be available to you, please refer to the Villanova University Cafeteria Plan and Summary Plan Description.

PURPOSE OF THE PLAN

The purpose of the Plan is to provide you and your eligible dependents with health and welfare benefits. The Plan provides certain benefits to you automatically and permits you to purchase certain optional benefits, as follows.

Benefits Provided Automatically

The following benefits are provided to eligible employees automatically (subject to any applicable eligibility requirements described below):

- Basic Life and Accident Coverage
- Short Term Disability Coverage
- Long Term Disability Coverage
- Business Travel Accident Coverage
- Employee Assistance Coverage
- Health Advocacy Coverage
- Tuition Remission Coverage
- Tuition Exchange Coverage
- Backup Care Reimbursement Program

Optional Benefits

If you are an eligible employee, you may purchase the following optional benefits (subject to any applicable eligibility requirements described below):

- Medical Coverage (including vision and prescription drug coverage)
- Dental Coverage
- Supplemental Life Insurance Coverage
- Commuter Benefit Plan

In addition, the University offers the following optional insurance and other coverage: Legal Services Coverage (Hyatt Legal), Identity Theft Coverage (ID Theft Assist), and Pet Insurance Coverage (Veterinary Pet Insurance (VPI)). Unlike the other benefits offered by the University, the University does not have any role in administering these insurance coverage options other than to remit your payroll deduction contributions to the appropriate vendors. These benefits are offered for your convenience only and the arrangements are not subject to ERISA. Participation is completely voluntary. Please refer to the University's Web site or the enrollment brochure for more information.

Retiree Benefits

If you are an eligible retiree, you may purchase health coverage for yourself and your spouse until you reach age 65. In addition, basic life insurance benefits are provided to you if you are an eligible retiree. Note that the University will not contribute to the cost of health coverage or provide life insurance benefits to eligible retirees who retire from employment with the University after May 31, 2018. Retiree health coverage after age 65 is described in the Villanova University Post-65 Retiree Medical Plan and Summary Plan Description. You may request a copy of this document from the Human Resources Department.

ELIGIBILITY AND PARTICIPATION

The following sections provide a general description of the Plan's eligibility and participation rules. Please keep in mind, however, that the booklets describing the specific benefits provided under the Plan may contain slightly different rules for determining eligibility status; these specific rules shall prevail over the general rules set forth in this booklet. If you have questions about your (or your dependents') eligibility status, you should check with your Human Resources benefit representative.

Eligible Employees

All full-time staff and full-time faculty of the University are eligible to participate in the Plan. Full-time status is determined in accordance with the University's personnel policies and practices in force at the time of the determination of eligibility. Except as provided in the following paragraph, the following individuals are ineligible to participate in the Plan: (1) part-time employees (*i.e.*, employees not considered "full-time"), (2) temporary employees, (3) those individuals who perform services for the University pursuant to an arrangement with a leasing organization, including but not limited to "leased employees," (4) those individuals who are not on the University payroll (such as consultants and independent contractors), whether or not they are later determined to be employees of the University, and (5) other non-regular employees as determined in accordance with the University's personnel policies and practices.

Part-time faculty and staff are eligible for Tuition Remission Benefits according to a schedule based on years of service and hire date. Part-time faculty and staff are not eligible for Tuition Exchange Benefits. Effective when required under the applicable provisions of the Affordable Care Act, part-time and temporary employees who work 30 or more hours per week (as determined by the University) will be eligible for health care coverage under this Plan.

Full-time employees of the Augustinian Provinciate are only eligible for Medical Coverage, Dental Coverage and Life and Accident Coverage under the Plan. Augustinian priests who are full-time employees of the University are eligible for all benefits under the Plan except Medical Coverage, Retiree Benefits and Tuition Remission Coverage. Western Province priests who are full-time faculty members of the University are eligible for the benefits set forth in the service contract between the Western Province and the University.

Eligible Dependents for Medical and Dental Coverage

If you are an eligible employee, you may elect Medical Coverage and Dental Coverage for your eligible dependents provided you choose coverage for yourself.

- Spouse - A spouse is the individual to whom you are legally married, provided that such marriage and legal spouse are recognized under Pennsylvania law.
- Child - A child is a child who has not yet attained age 26. In addition, certain children may be covered beyond age 26 if they are unable to support themselves due to physical disability or mental disability, if they were covered under the Plan prior to attaining age 26. The following children may qualify for Medical and Dental Coverage under the Plan:

- a biological child;
- a legally adopted child or a child placed with you for adoption;
- a stepchild living with you;
- a child who is under your legal guardianship; or
- a foster child.

If you elect to provide benefits for an eligible child described above who is not a biological child, a legally adopted child, a stepchild or a foster child and you do not claim him or her as a dependent on your individual tax return, the value of the Medical and/or Dental Coverage provided to such child will be reported on your IRS Form W-2 from the University and be taxable to you as ordinary income.

Children who must be covered under the Plan in accordance with a qualified medical child support order (“QMCSO”) will be covered beginning on the earliest possible date following the date the order is approved by the University or, if later, the date specified in the QMCSO. Coverage will continue until the date or age stipulated in the QMCSO. However, children may not be covered beyond the date they would cease to be eligible for coverage under the ordinary terms of the Plan. See QUALIFIED MEDICAL CHILD SUPPORT ORDER for more information.

Your eligible spouse and children automatically receive coverage under the employee assistance plan.

Eligible Dependents for Life Insurance Coverage

If you are an eligible employee, you may elect Life Insurance Coverage for your eligible dependents provided you choose coverage for yourself.

- Spouse - A spouse is the individual to whom you are legally married, provided that such marriage and legal spouse are recognized under Pennsylvania law.
- Dependent Child - A dependent child is an unmarried child to age 19 (or to age 25 if regularly attending school on a full-time basis) who is dependent on you for support and maintenance. In addition, certain children may be covered beyond age 19 if they are unable to support themselves due to physical disability or mental disability, if they were covered under the Plan prior to attaining age 19. The following children may qualify as dependents:
 - a biological child;
 - a legally adopted child or a child placed with you for adoption;
 - a stepchild living with you;
 - a child living with you, for whom you provide support and who is related to you by blood or marriage;
 - a child who is under your legal guardianship; or
 - a foster child.

Please note that the definitions of dependent set forth above only apply to medical, dental and life insurance benefits. For the dependent eligibility rules for other Plan rules, refer to the applicable section of this document or the University's Web site.

Participation for Eligible Employees

If you are an eligible employee, you may elect to participate in the Plan as of the first of the month following the later of your date of hire or the date you first become eligible to participate. To become a participant, you must follow the enrollment process prescribed by the Plan Administrator and authorize and pay any required contribution(s). If dependent coverage is available (and elected), this dependent coverage will begin when your coverage begins. Once you make an election to participate in the Plan, you may change that election only (1) if you have a change in status, as described below under CHANGING YOUR ELECTION, or (2) during an open enrollment period at then applicable rates. If you fail to make an election for benefits upon your initial eligibility for coverage, you will be deemed to have elected no benefits. If you fail to make an election for benefits during the open enrollment period preceding any subsequent Plan Year, you will be deemed to have elected to maintain the same benefit coverage elections (at the applicable rates), unless the University communicates otherwise. Therefore, it is extremely important that you enroll in the Plan within the time period prescribed by the Plan Administrator.

Resumption of Participation

If you terminate employment or otherwise cease to be an eligible employee and again become an eligible employee, you will be permitted to make new elections under the Plan after you again satisfy the eligibility requirements described above.

Special Provisions for Eligible Retirees and their Spouses

All full-time employees who retire from the University between age 62 and 65 and who have completed 10 or more years of active credited service may elect to continue health coverage under the Plan until they reach age 65. Full-time status is determined in accordance with the University's personnel policies and practices in force at the time of the determination of eligibility. If you are an eligible retiree, you may also elect to continue coverage for your spouse and any eligible dependents, until you reach age 65.

If you are an eligible retiree, you may elect to participate in the Plan as of the first of the month following your retirement date. To become a participant, you must follow the enrollment process prescribed by the Plan Administrator and authorize and pay any required contribution(s).

Sunset of University Contributions for Retiree Coverage

If you retire from employment with the University after May 31, 2018, the University will not contribute to the cost of your, your spouse's or your eligible dependents' health coverage under this Plan.

CESSATION OF PARTICIPATION

Cessation of Participation for Eligible Employees and Eligible Retirees

Participation under the Plan (or any benefit option under the Plan, if applicable) will terminate as of the first to occur of the following:

- the date on which the Plan terminates,
- the date on which you cease to be an eligible employee or eligible retiree, whichever applies,
- the first day of any Plan Year in which you elect not to participate, the date as of which you fail to make a required contribution, or
- the date as of which you revoke your election of coverage, as described below under COVERAGE OPTIONS AND ENROLLMENT.

The University may retroactively terminate your Medical Coverage if you engage in fraud or make an intentional misrepresentation of material fact. Rescissions of coverage will be effective as of the date of the fraud or intentional misrepresentation. You will receive at least 30 days advance written notice in the event of rescission of your coverage.

Cessation of Participation for Dependents

Participation under the Plan (or any benefit option under the Plan, if applicable) will terminate as of the first to occur of the following:

- the date as of which the eligible employee or eligible retiree, as applicable, ceases to be covered by the Plan (or benefit option),
- the date on which the Plan terminates,
- the last day of the month in which the dependent ceases to meet the applicable definition of dependent,
- the first day of any Plan Year in which dependent coverage is not elected,
- the date as of which the eligible employee or eligible retiree, as applicable, fails to make a required contribution, or
- the date as of which the eligible employee or eligible retiree, as applicable, revokes an election of dependent coverage, as described below under COVERAGE OPTIONS AND ENROLLMENT.

Authorized Leaves of Absence

The University may continue coverage during certain periods of absence, such as absence by reason of sickness, disability, or other authorized leave of absence (including military leave), in accordance with its written personnel policies and practices and to the extent prescribed by law. If benefits are continued during a period of unpaid leave of absence, your contributions, if any, must be made in accordance with the University's personnel policies and practices.

Leave Under Family Medical Leave Act (FMLA)

If you take a leave of absence for your own serious health condition or to care for a family member with a serious health condition or to care for a newborn or adopted child, you will be able to continue your health coverage under the Plan, provided you pay any applicable contribution(s). If you drop your health coverage during the leave, you will not have any coverage for yourself and/or your eligible dependents. Once you return from your leave, you can elect to have your health coverage reinstated on the date you return to work, assuming you pay any contributions required for the coverage. Other coverages may also be reinstated. You will receive more information about your choices if you take an FMLA leave.

The National Defense Authorization Act of 2008 amended the FMLA to add two forms of military leave - qualifying exigency leave and military caregiver leave. If a member of your family serves in the military, you have special job-protected leave rights to care for that family member if he or she is wounded or injured while serving. The Act also gives you special job-protected leave to help you and your family manage your affairs when a service member is called to active duty, including caring for a military family member's parent who is incapable of self-care when the care is necessitated by the member's active duty. For more information on FMLA, contact the Human Resources Department.

Military Leave

If you take a leave of absence from the University to serve in the U.S. Armed Forces, Plan coverage for you and your dependents will continue to be available pursuant to the requirements of applicable law, including the Uniformed Services Employment and Reemployment Rights Act (USERRA), the Veterans Benefits Improvement Act of 2004 (VBIA), and the Heroes Earnings Assistance and Relief Tax Act of 2008 (HEART Act). For more information, see CONTINUATION COVERAGE DURING MILITARY SERVICE or contact the Human Resources Department.

COST OF COVERAGE

The University shares the cost of coverage for certain options under this Plan with eligible employees. To the extent you are required to make contributions, you must authorize the appropriate payroll deduction. Some contributions are made on a pre-tax basis and some contributions are made on an after-tax basis. Pre-tax contributions are made pursuant to the terms of the Villanova University Cafeteria Plan. Some benefits are fully paid by the University.

The University sets the level of any employee contributions. The University reserves the right to change the level of employee contributions at any time. To make contributions, either pre-tax or after-tax, you must authorize the University to deduct the appropriate contribution from your pay check. "Pre-tax" means that the cost of coverage will be deducted from your pay before federal income taxes, social security taxes and in most cases state or local income taxes are withheld. Please keep in mind, however, that your contributions may still be subject to state or local taxes in some states.

The University shares the cost of coverage for health plan options under this Plan with eligible retirees who retire on or before May 31, 2018. To the extent you are required to make contributions, you must pay the difference between the monthly cost for the health plan option in

which you are enrolled and the University's retiree allowance. The University sets the level of any retiree contributions. The University reserves the right to change the level of retiree contributions at any time.

COVERAGE OPTIONS AND ENROLLMENT

During each annual open enrollment period, you will be given the opportunity to make your benefit choices for the upcoming Plan Year (June 1 through May 31). Except as provided in the following sentence, if you do not elect to change your selection from the previous year, the University assumes that you want to continue under the same option(s), subject to the payment of the applicable contribution(s). However, to contribute to a Dependent Care Flexible Spending Account or a Health Care Flexible Spending Account or participate in a Child Care Subsidy Account under the University's Cafeteria Plan, you must make an election for each Plan Year. Note that the availability of a particular option may be governed by an insurance contract or other provider agreement that contains specific eligibility guidelines or other criteria not specifically mentioned in this booklet.

Generally, you may not make changes to your coverage elections during the Plan Year. (This restriction is due to requirements under federal law.) Consistent with the Villanova University Cafeteria Plan, you may make a change to an election that is on account of and consistent with one of the events described below. If you have a change in family or work status - sometimes referred to as a "Life Event" - or under certain other circumstances, you may join, re-join, opt out, increase or decrease coverage (e.g., change from employee to family coverage or vice versa) if you notify the Plan Administrator within 31 days of the change. The following list describes circumstances that may permit you to make a mid-year election change.

If one or more of the following Life Events occur, you may revoke your old election during the year and make a new election; provided, that both the revocation and new election are on account of and correspond with the Life Event (as described below). Those occurrences that qualify as Life Events include the events described below, as well as any other events that the Plan Administrator determines are permitted under applicable regulations:

- Change in Marital Status - a change in your legal marital status (such as marriage, legal separation, annulment, divorce or death of your spouse),
- Change in Number of Dependents - a change in the number of your dependents (such as the birth of a child, adoption or placement for adoption of a dependent, or death of a dependent),
- Change in Employment Status - any of the following events that change the employment status of you, your spouse or your dependent that affects benefit eligibility under an employee benefit plan (including this Plan) of you, your spouse or your dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, or switching between part-time and full-time, incurring a reduction or increase in hours of employment, or any other similar change that makes the

individual become (or cease to be) eligible for a particular benefit under this or another plan,

- Change in Dependent Eligibility - an event that causes your dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit, such as attainment of age, student status, or any similar circumstance, or
- Change in Residence - a change in your, your spouse's or your dependent's place of residence.

If a Life Event occurs, you must provide documentation to the Plan Administrator and make the appropriate change to your benefit elections using the on-line benefits enrollment program within 31 days of the Life Event. Your coverage change will be effective on the first day of the month after you provide timely notice to the Plan Administrator. However, if the Life Event is a birth, adoption, or placement for adoption of a dependent child, coverage will be retroactively provided to the date of the event, again subject to timely notice of the event.

If you wish to change your election based on a Life Event, you must establish that the revocation of your existing election and the new election are on account of and correspond with the Life Event. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of and corresponds with a Life Event, as described in applicable regulations. As a general rule, a desired election change will be found to be consistent with a Life Event if the event affects coverage eligibility and the change responds to that election change. (This means, for example, that you may be limited to adding or dropping dependents, rather than changing coverage options.) In addition, you must also satisfy the following specific requirements in order to alter your election based on the Life Event:

- Life Event Involving Loss of Dependent Eligibility - A special rule governs which type of election change is consistent with the Life Event. For a Life Event involving (a) divorce, annulment or legal separation from your spouse, (b) the death of your spouse or your dependent, or (c) your dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel coverage for any individual other than a person losing eligibility as a result of the event would fail to correspond with that Life Event.
- Life Event Involving Coverage Eligibility Under Another Plan - For a Life Event in which you, your spouse or your dependent gain eligibility for coverage under another employer's plan as a result of a change in your marital status or a change in your, your spouse's or your dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Life Event only if coverage for that individual becomes effective or is increased under the other employer's plan.

Special Enrollment Rights. If you, your spouse and/or a dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (*i.e.*, due to legal separation, divorce,

death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible dependents who lost such coverage. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your spouse, and your newly acquired dependents; provided, that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Furthermore, if you, your spouse and/or a dependent loses eligibility for coverage under Medicaid or a state's Children's Health Insurance Program ("CHIP"), or you or your dependent become eligible for state premium assistance under Medicaid or CHIP, you may enroll in medical coverage under this Plan if you notify the University within 60 days of the event. Please refer to the applicable medical coverage booklet for an explanation of special enrollment rights.

Certain Judgments and Orders. If a judgment, decree or order, including a Qualified Medical Child Support Order (QMCSO), requires your dependent child (including a foster child who is your tax dependent) to be covered under this Plan, you may change your election to provide coverage for the dependent child. The child must otherwise meet the Plan's definition of a dependent (e.g., the age requirement). If the order requires that another individual (such as your former spouse) cover the dependent child, you may change your election to revoke coverage for the dependent child.

Entitlement to Medicare or Medicaid. If you, your spouse, or a dependent actually enroll in Medicare or Medicaid, you may cancel that person's health coverage. Similarly, if you, your spouse, or a dependent who has been enrolled in Medicare or Medicaid loses eligibility for the same, you may, subject to the terms of the underlying plan, elect to begin that person's health coverage.

Change in Coverage. If the Plan Administrator notifies you that your coverage under the Plan will be significantly curtailed during the Plan Year, you may revoke your election and elect coverage under another plan option that provides similar coverage. You may also revoke your election if there is a *significant* curtailment that amounts to a loss of coverage (e.g., an HMO ceases to be available) and there is no other benefit option that provides similar coverage. However, if there is a *significant* curtailment that does not amount to a loss of coverage (e.g., an increase in deductibles or co-payments), you may not drop your coverage but only switch to a similar coverage. Also, if during the Plan Year the Plan adds or eliminates a benefit option, you may elect the newly-added option or elect another benefit option (when a Plan option has been eliminated). Additionally, you may make an election change when there is a significant improvement in coverage provided under an existing benefit option. Finally, you may make an election change that is on account of and corresponds with a change made under the plan of your spouse's, former spouse's or dependent's employer, so long as: (a) his or her employer's plan permits its participants to make an election change permitted under applicable regulations; or (b) the plan year of the other plan is other than June 1 - May 31.

Except as provided in the last two items above, in no event are you permitted to change health insurance providers during the Plan Year. Such a change may take place only during the annual open enrollment period prior to each Plan Year.

BENEFITS

This section briefly summarizes the health and welfare benefits available under the Plan and describes some important rules regarding your annual elections under the Plan. For a more complete description of the benefits available under each coverage option, please refer to the separate descriptive booklets that you have received from the University, insurance companies and third party administrators.

Medical Coverage (including vision and prescription drug coverage)

You have a choice of several medical coverage options, as described in the enrollment brochure and booklets prepared by the insurers or third party administrators. You should make your decision based on your health care needs and those of your dependents. In determining coverage options for you and your dependents, you should consider whether or not you have dependents residing outside of the provider's coverage area or any restrictions that a provider may have with regard to coverage while traveling. Your dependents must participate in the option you select.

Special Rules Related to Pregnancy and Childbirth. The Plan 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 normal delivery, or less than 96 hours following a cesarean section, or require that a health care provider obtain authorization from the Plan or any insurance issuer (including an HMO) for prescribing a length of stay not in excess of the above periods. 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).

Special Coverages Required by the Women's Health and Cancer Rights Act. The Women's Health and Cancer Rights Act of 1998 requires the Plan to cover the following medical services in connection with coverage for a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Protheses and physical complications in all stages of mastectomy, including lymphedemas.

These services will be provided in a manner determined in consultation with the attending physician and the patient. Coverage for these medical services are subject to any applicable deductibles and coinsurance amounts.

Premium Assistance Under Medicaid and the Children's Health Insurance Program. Some states have premium assistance programs that can help pay for medical coverage for those who are unable to afford the premiums. Refer to the special notice in your enrollment brochure for more information.

Nondiscrimination Based on Health Factor. The Plan generally may not establish any rule for eligibility to enroll in the Plan (including continued eligibility) that discriminates against an

employee or dependent because of a health factor or charge higher premiums on account of a health factor. "Health factors" include with respect to an individual (i) health status; (ii) medical condition; (iii) claims experience; (iv) receipt of health care; (v) medical history; (vi) genetic information; (vii) evidence of insurability or (viii) disability. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits the University from discriminating against you or your eligible dependents on the basis of genetic information.

Decisions on Health Care. The Plan's health care benefits provide solely for the payment of certain health care expenses. All decisions regarding health care will be solely the responsibility of each covered individual in consultation with the personal health care provider selected by the individual. The Plan and any applicable insurance contracts contain rules for determining the percentage of allowable health care expenses that will be reimbursed and whether particular treatments or health care expenses are eligible for reimbursement. The covered individual in accordance with the Plan's claims procedure may dispute any decision with respect to the level of health care reimbursement, or the coverage of a particular health care expense. Each covered individual may use any source of care for health treatment and health coverage as selected by such individual, and neither the Plan nor the University will have any obligation for the cost or legal liability for the outcome of such care, or as a result of a decision by a covered individual not to seek or obtain such care, other than liability under the Plan for the payment of covered expenses.

Mental Health Parity. The Plan must ensure that the financial requirements that apply to the mental health or substance abuse benefits are no more restrictive than the most common or frequent financial requirements that apply to substantially all medical and surgical benefits covered under the Plan. "Financial requirements" include deductibles, co-payments, co-insurance and out-of-pocket expenses. If you have any questions regarding the mental health parity rules and how they may apply to you or your eligible dependents, please contact the Human Resources Department.

Privacy of Health Information. The receipt, use and disclosure of protected health information is governed by regulations issued under the Health Insurance Portability and Accountability Act (commonly referred to as "HIPAA"). In accordance with these regulations, the Plan Administrator, certain employees working with, and on behalf of, the Plan and the Plan's business associates may receive, use and disclose protected health information in order to carry out the payment, treatment and health care operations under of the Plan. These entities and individuals may use protected health information for such purposes without your authorization. If your protected health information is used or disclosed for any other purpose (other than as specifically required or authorized under HIPAA), the Plan must first obtain your written authorization for such use or disclosure. Refer to Appendix C and the Plan's Privacy Notice for more information on medical records privacy. The Privacy Notice is available on the University's Web site or from the Human Resources Department.

Dental Coverage

You have the option to purchase dental coverage for yourself and your dependents. There is an annual per person and family deductible and an annual maximum benefit for this coverage. Dental coverage is not available under the Plan if you are an eligible retiree.

If you have other dental coverage under a spouse's plan, or you do not want coverage at all, you may waive dental coverage.

Employee Assistance Plan (EAP) Coverage

You automatically receive coverage under the Employee Assistance Plan to aid you and your dependents in dealing with personal and work-related issues, such as parenting, retirement, health and wellness and emotional well-being. The **EAP+Work/Life** program provided through Health Advocate offers short-term counseling and support for personal, family and work issues. Health Advocate is available on a 24/7 basis, and ensures that all personal information is kept confidential and private. EAP coverage is not available under the Plan if you are an eligible retiree.

Health Advocacy Coverage

You automatically receive coverage under the Health Advocacy program to aid you and your dependents in navigating the complex healthcare and insurance systems. The Healthcare Help program provided through Health Advocate offers personalized help to resolve clinical and administrative issues involving medical, hospital, dental, pharmacy and other healthcare needs. Health Advocate is available on a 24/7 basis, and ensures that all personal information is kept confidential and private. Health Advocacy coverage is not available under the Plan if you are an eligible retiree.

Life and Accident Coverage

Basic Life Insurance - The University provides the greater of \$50,000 or one times salary (up to a maximum of \$250,000) of basic group term life insurance to eligible employees, which includes an accidental death and dismemberment provision (AD&D). If your death is the result of a covered accident, your beneficiary will receive an accidental death benefit equal to the amount of your basic life insurance benefit. If you suffer the loss of a limb or the loss of eyesight as a result of a covered accident, you will receive 100% or 50% of the AD&D benefit depending on the extent of the loss.

Under current federal tax laws, any life insurance coverage provided by the University in excess of \$50,000 results in taxable income to you. Although this income is not actually received by you in your paycheck, it is taxable to you and is reported as such on your Form W-2. If you wish to avoid additional taxes, you may elect to receive only \$50,000 of basic life insurance coverage.

Coverage is reduced by 50% for faculty and staff who are actively employed beyond age 70.

The University provides \$5,000 of basic group term life insurance to retirees who retire on or before May 31, 2018.

Supplemental Life Insurance - If you are an eligible employee and you want life insurance coverage in addition to basic life insurance, you may elect to purchase supplemental insurance coverage in multiples of salary up to the lesser of seven times salary or \$1,000,000. Depending on how much supplemental coverage you purchase, evidence of insurability may be required. The premiums for this coverage will be made through payroll deductions.

There is no AD&D coverage for Supplemental Life Insurance. Supplemental life insurance is reduced by 50% for faculty and staff who are actively employed beyond age 70.

Dependent Life Insurance - If you are an eligible employee, you have the option to purchase dependent life insurance of \$25,000 or \$50,000 (subject to evidence of insurability) to provide financial protection to you if your spouse dies. You may also purchase life insurance of \$10,000 for each of your eligible children. Your children can be covered until age 19, or if they are full-time students, until age 25 or when their full-time status ends. Note that the dependent life insurance amount for a newborn child up to the age of 6 months is \$500, after which it increases to \$10,000. The premiums for this coverage will be made through payroll deductions.

If both husband and wife are actively employed by the University, the purchase of dependent life insurance is not permitted for the spouse.

If you terminate your employment with the University, your life insurance coverage will be terminated on your termination date. You may be able to convert your coverage into an individual policy upon termination of employment, provided you request conversion directly from the insurance company within the required timeframe.

Short-Term Disability Insurance

If you are an eligible employee and you are unable to work due to a non-work-related illness or injury after the 1st of the month following your date of hire, the University provides short-term disability (“STD”) coverage at no cost to you. After a 10-day waiting period, during which you can use your accrued sick leave (or vacation leave if no sick leave is available), 70% of your regular salary is provided for up to 170 calendar days. You must use all of your available sick time and at least half of your available vacation time for each day that you are unable to work in order to receive 100% of your regular salary during your disability. You may elect to use more of your available vacation time for this purpose if you would like.

This benefit is taxable to you as regular pay. Your STD benefits may be reduced by deductible sources of income (such as any salary continuance plan provided by or through the University).

If you receive STD benefits from the University, you may continue to participate in the University medical and dental coverages as though you were an active employee provided the required contribution(s) are made.

Long-Term Disability Insurance

If you are an eligible employee and you are unable to work due to non-work-related illness or injury, you may be eligible to receive long-term disability (“LTD”) benefits. All of the cost of long-term disability coverage is paid by the University. To the extent that the University provides coverage to you, any resulting benefits paid to you will be fully taxable when paid. If you are determined by the insurance company listed in Appendix A to be disabled within the meaning of the contract, benefits commence once you have been absent from work due to illness or injury for a period in excess of one hundred and eighty continuous days and will be equal to 60% of your monthly earnings up to a maximum monthly dollar amount of \$11,500. Your LTD benefits may be offset by other sources of income and disability earnings, including but not

limited to any payments under any state compulsory benefit law, other group insurance plan or sick leave, salary continuance plan provided by or through the University or University-sponsored pension income (including disability and/or other retirement income). The duration of benefit payments may be limited in certain circumstances. If you terminate your employment with the University, your LTD coverage will be terminated on your termination date. Please refer to the descriptive information provided by the insurance company listed in Appendix A for more information.

Coverage under LTD is excluded for one year if a disability occurs within three months before the employee's most recent effective date of insurance coverage. Under LTD, participation in the University medical and dental plans may be continued on the same basis as active employees for up to two years from the initial date of long-term disability provided the required contribution(s) are made.

Business Travel Accident Insurance

If you are an eligible employee, you automatically receive business travel accident protection if you die or become seriously injured while traveling on University business. The amount of coverage is ten times your annual salary, up to a maximum of \$1,000,000 with a minimum of \$500,000. Coverage is reduced to a maximum of \$250,000 for faculty and staff who are actively employed beyond age 70.

Tuition Remission

Either full or partial tuition remission is provided at the University depending upon the employment status of full time or part time (1) for staff member's study beginning the next semester or summer session following the completion of six months of service, and (2) for faculty member's study beginning with the next semester or summer session following their first semester of teaching. Staff members may take a maximum of three (3) undergraduate courses per semester and a maximum of two (2) graduate courses per semester. Classes must be taken outside of the staff member's normal work schedule, unless both the Department head and Associate Vice President of Human Resources approve an exception. Faculty members are not restricted on the number of courses taken, however, faculty members may not take courses for credit in their own departments. Federal and state income taxes will generally apply to tuition remission benefits for faculty and staff members for graduate level courses over \$5,250.

For eligible staff and faculty who are employed on or after August 30, 1999 or later, partial tuition remission, subject to a co-payment, is provided for the spouse (as recognized under Pennsylvania law) and dependent biological or adopted children who attend the University beginning with the next semester or summer session following the faculty or staff member's completion of three (3) years of continuous full time service. The amount of tuition remission equals 85% of the applicable Villanova University tuition rate with a co-payment amount to be paid by the eligible employee equal to the remaining 15% of the applicable rate. For staff and faculty who were employed prior to August 30, 1999, full tuition remission is provided for the spouse and dependent biological or adopted children who attend the University beginning with the next semester or summer session following the faculty or staff member's completion of three (3) years of continuous full time service. Part-time faculty and staff and their spouses (as

recognized under Pennsylvania law) and dependent children can receive a percentage of tuition remission based on the employee's completed years of continuous service. Prospective students must meet normal admission and eligibility requirements. Tuition remission for spouses and children is limited to undergraduate courses, except for certain graduate level courses which may substitute for undergraduate courses. Tuition remission is available only for courses taken on the University's campus and for which tuition charges are billed by the Bursar. Non-credit Continuing Studies courses, study abroad, and other credit work at locations away from the main campus are not covered by the tuition remission program.

Tuition remission does not cover any fees or expenses associated with being a student at the University (*i.e.*, general fee, student health fee, room and board, the cost of required travel, laptop computers, etc.). Please note that some University programs are not covered under tuition remission. Please consult with Human Resources and the program director before you apply.

Please refer to the University's Employee Handbook on the University Web site for further information on requirements, restrictions and the application procedure for tuition remission.

Tuition Exchange

Tuition Exchange ("TE") is a tuition scholarship program (for dependent, biological or adopted children of full-time employees only) at schools other than the University. Under the National Tuition Exchange Program, attendance at other member schools may be available, depending on various factors. Currently, initial eligibility for two (2) years of TE is based on five (5) years of full-time continuous service as of September 1 of the year in which the TE will be used. The number of TE slots available to employees each year is based on Villanova's credit balance within the consortium. Therefore, it is possible that there will be a limit on the number of employees who can use the program from year to year. Similarly, neither the acceptance at member institutions nor the award of TE is guaranteed under the TE program. For this reason, parents are encouraged to view TE as one of their many options in funding their child's education, rather than the sole option. Please refer to the University's Employee Handbook on the University Web site for further information.

Backup Care Reimbursement Benefit

You automatically receive coverage under the Backup Care Reimbursement Benefit (provided you complete and submit the enrollment forms as required by the Plan Administrator) to aid you in providing care for certain dependents in *emergency* situations. Backup Care Reimbursement coverage is not available under the Plan if you are an eligible retiree.

This benefit includes:

- Publications to aid you in the creation and design of your emergency backup care plan;
- Free telephone consultations with child care consultants; and
- A taxable financial subsidy that reimburses you for certain emergency backup dependent care up to \$50.00 a day for up to 5 days per year (a maximum benefit of \$250.00 annually per family).

The financial subsidy may be used to offset the cost of *emergency* backup care provided by an agency, in-home caregiver, friend, relative or neighbor *when your regular arrangement is not available*. It may not be used to pay a child's parent, step-parent or anyone claimed as a dependent on your or your spouse's tax returns. The subsidy is offered on a taxable basis. All appropriate taxes will be withheld in accordance with federal, state and local requirements. Please refer to the University's Web site for more information about this benefit.

Eligible dependents for whom you may seek reimbursement for care under this benefit are your:

- Children up to age 12;
- Spouse (as recognized under Pennsylvania law) who is disabled or who is normally independent and needs temporary/personal care; and
- Parent(s), parent(s)-in-law and/or other adults who are disabled or are normally independent and need temporary care.

How to File for Reimbursement. After paying the backup care provider, you must submit an Emergency Care Affidavit/Employee Reimbursement Form signed by both you and the provider. Reimbursement will be made through the payroll system following claim approval by Health Advocate. All claims approved in any given month by Health Advocate will be reimbursed by the University the following month through the standard payroll schedules. Reimbursement forms are available on the University's Web site or from the Human Resources Department.

Commuter Benefit Plan

The Commuter Benefit Plan allows you to pay for eligible transit expenses through pre-tax payroll deductions up to the maximum amount established by the Internal Revenue Service each calendar year. The Plan is intended to qualify as a "qualified transportation fringe" benefit plan under Internal Revenue Code section 132(f). To participate in the Commuter Benefit Plan, you must enroll online at www.wageworks.com. Your monthly transit contribution will be deducted from your paycheck for the following month's transportation expense. For example, the deduction taken in your November paycheck will be for December's transit purchase. You may change your election on a monthly basis, provided you do so within the required timeframe.

Please refer to the University's Web site for more information about this benefit.

LOSS OF BENEFITS

Except as otherwise described in this document, your coverage ends when your employment with the University terminates. This will occur upon your retirement, resignation, discharge, or death. The University will, however, discuss with you at your request what, if any, arrangements may be made to continue coverage beyond the date your employment ceases. The section entitled CONTINUATION OF COVERAGE UNDER COBRA also describes certain circumstances under which health care coverage may be continued after the date your employment ends, or, in the case of your dependents, after the date on which they become ineligible for health care coverage under the Plan.

In some cases, Tuition Remission and Tuition Exchange benefits may continue after your retirement, death or disability. Please refer to the University's Employee Handbook on the University Web site for further information.

CLAIMS AND APPEALS PROCEDURES

The booklets and other materials that describe a particular benefit under the Plan generally will contain a specific set of claims and appeals procedures that you must follow to make a claim to receive that particular benefit and/or to appeal a denied claim for that particular benefit. Although these separate claims and appeals procedures will be very similar in most respects, there may be important differences. As such, you should follow the specific claims and appeals procedures for a particular benefit very carefully. If the booklets and other materials that describe a particular benefit do not contain a specific set of claims and appeals procedures, the Plan's default procedures as described below will apply. If you have any questions about which set of claims and appeals procedures to follow or any other questions about making a claim, you should contact the Plan Administrator immediately.

For purposes of this section of the SPD describing the Plan's default claims and appeals procedures, the Plan Administrator, or any third party to whom the Plan Administrator has delegated the authority to review and evaluate claims, such as an insurance company, shall be referred to as the "Claims Administrator" at the initial claim level and the "Appeals Administrator" at the appeal level. Refer to Appendix B for details.

A request for benefits is a "claim" subject to these procedures only if you or your authorized representative file it in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable provider identified in Appendix A. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim) must be filed with the Plan Administrator at the address set forth in the ADDITIONAL INFORMATION section below. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to allow the Claims Administrator to process the claim, you will be given an opportunity to provide the missing information.

If you want to bring a claim for benefits under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the Claims Administrator and/or the Appeals Administrator identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of your medical condition may act as your authorized representative with or without prior notice.

IMPORTANT: The procedures set forth below do not apply to the coverage under Tuition Remission, Tuition Exchange, the Backup Care Reimbursement Program, the Health Advocacy Program or the Commuter Benefit Plan as these benefits are not subject to the Employee Retirement Income Security Act of 1974. Contact the Human Resources Department with questions regarding these benefits.

Claims Not Involving Health Benefits

In the case of a claim not involving health benefits (e.g., Life, AD&D, LTD and STD), initial claims for benefits under the Plan shall be made by you in writing to the Claims Administrator.

- Time Periods for Responding to Initial Claims - If you bring a claim for benefits under the Plan, the Claims Administrator will respond to you within 90 days (45 days for a claim involving disability benefits) after receipt of the claim. For claims other than claims involving disability benefits, if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 90-day period that the Claims Administrator needs up to an additional 90 days to review your claim. In the case of a claim involving disability benefits, the Claims Administrator will notify you within the initial 45-day period that the Claims Administrator needs up to an additional 30 days to review your claim. If the Claims Administrator determines that additional time is necessary to review your claim for disability benefits, the Claims Administrator may notify you of an additional 30-day extension.
- Notice and Information Contained in Notice Denying Initial Claim - If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice of the denial. This notice will include the following:
 - *Reason for the Denial* - the specific reason or reasons for the denial;
 - *Reference to Plan Provisions* - reference to the specific Plan provisions on which the denial is based;
 - *Description of Additional Material* - a description of any additional material or information necessary for you to perfect your claim and an explanation as to why such information is necessary;
 - *Description of Any Internal Rules* - in the case of any claim involving disability benefits, a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the determination and that a copy of such rule will be provided to you free of charge at your request; and
 - *Description of Claims Appeals Procedures* - a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will

include a statement that you are eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal).

- Appealing a Denied Claim for Benefits - If the Claims Administrator denies your initial claim for benefits, you may appeal the denial by filing a written request with the Appeals Administrator within 60 days (180 days in the case of a claim involving disability benefits) after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Appeals Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your appeal.
- Time Periods for Responding to Appealed Claims - If you bring a claim for benefits under the Plan, the Claims Administrator will respond to you within 60 days (45 days in the case of a claim involving disability benefits) after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 60-day period that the Claims Administrator needs up to an additional 60 days (45 days in the case of a claim involving disability benefits) to review your claim.
- Notice and Information Contained in Notice Denying Appeal - If the Appeals Administrator denies your claim (in whole or in part), the Appeals Administrator will provide you with written notice of the denial. This notice will include the following:
 - *Reason for the Denial* - the specific reason or reasons for the denial;
 - *Reference to Plan Provisions* - reference to the specific Plan provisions on which the denial is based;
 - *Statement of Entitlement to Documents* - a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits;
 - *Description of Any Internal Rules* - in the case of a claim involving disability benefits, a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
 - *Statement of Right to Bring Action* - a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits.

The decision of the Appeals Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you challenge the decision of the Appeals Administrator, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before you can pursue the claim in federal court. Facts and evidence that become known to you after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

Claims Involving Health Benefits

In the case of a claim involving health benefits (e.g., medical (including vision and prescription drug coverage), dental, and EAP), initial claims for benefits under the Plan shall be made by you in writing to the Claims Administrator.

- Types of Claims - There are several different types of claims that you may bring under the Plan. The Plan's procedures for evaluating claims (for example, the time limits for responding to claims and appeals) depend upon the particular type of claim. The types of claims that you generally may bring under the Plan are as follows:
 - *Pre-Service Claim* - A "pre-service claim" is a claim for a particular benefit under the Plan that is conditioned upon receiving prior approval in advance of receiving the benefit. A pre-service claim must contain, at a minimum, the name of the individual for whom benefits are being claimed, a specific medical condition or symptom, and a specific treatment, service or product for which approval is being requested.
 - *Post-Service Claim* - A "post-service claim" is a claim for payment for a particular benefit or for a particular service after the benefit or service has been provided. A post-service claim must contain the information requested on a claim form provided by the applicable provider.
 - *Urgent Care Claim* - An "urgent care claim" is a claim for benefits or services involving a sudden and urgent need for such benefits or services. A claim will be considered to involve urgent care if the Claims Administrator or a physician with knowledge of your condition determines that the application of the claims review procedures for non-urgent claims (i) could seriously jeopardize your life or your health, or your ability to regain maximum function, or (ii) in your physician's opinion, would subject you to severe pain that cannot adequately be managed without the care or treatment that is the subject of the claim.
 - *Concurrent Care Review Claim* - A "concurrent care review claim" is a claim relating to the continuation/reduction of an ongoing course of treatment.
- Time Periods for Responding to Initial Claims - If you bring a claim for benefits under the Plan, the Claims Administrator will respond to your claim within the following time periods:

- *Post-Service Claim* - In the case of a post-service claim, the Claims Administrator shall respond to you within 30 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 30-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is necessary because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.
- *Pre-Service Claim* - In the case of a pre-service claim, the Claims Administrator shall respond to you within 15 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 15-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.
- *Urgent Care Claim* - In the case of an urgent care claim, the Claims Administrator shall respond to you within 72 hours after receipt of the claim. If the Claims Administrator determines that it needs additional information to review your claim, the Claims Administrator will notify you within 24 hours after receipt of the claim and provide you with a description of the additional information that it needs to evaluate your claim. You will have no less than 48 hours from the time you receive this notice to provide the requested information. Once you provide the requested information, the Claims Administrator will evaluate your claim within 48 hours after the earlier of the Claims Administrator's receipt of the requested information, or the end of the extension period given to you to provide the requested information. There is a special time period for responding to a request to extend an ongoing course of treatment if the request is an urgent care claim. For these types of claims, the Claims Administrator must respond to you within 24 hours after receipt of the claim by the Plan (provided, that you make the claim at least 24 hours prior to the expiration of the ongoing course of treatment).
- *Concurrent Care Review Claim* - If the Plan has already approved an ongoing course of treatment for you and contemplates reducing or terminating the treatment, the Claims Administrator will notify you sufficiently in advance of the reduction or termination of treatment to allow you to appeal the Claims Administrator's decision and obtain a determination on review before the treatment is reduced or terminated.

- Notice and Information Contained in Notice Denying Initial Claim - If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally). This notice will include the following:
 - *Reason for the Denial* - the specific reason or reasons for the denial;
 - *Reference to Plan Provisions* - reference to the specific Plan provisions on which the denial is based;
 - *Description of Additional Material* - a description of any additional material or information necessary for you to perfect your claim and an explanation as to why such information is necessary;
 - *Description of Any Internal Rules* - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
 - *Description of Claims Appeals Procedures* - a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will include a statement that you are eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal and a description of any expedited review process for urgent care claims).
- Appealing a Denied Claim for Benefits - If the Claims Administrator denies your initial claim for benefits, you may appeal the denial by filing a written request (or an oral request in the case of an urgent care claim) with the Appeals Administrator within 180 days after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Appeals Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your appeal.
- Time Periods for Responding to Appealed Claims - If you appeal a denied claim for benefits, the Appeals Administrator will respond to your claim within the following time periods:
 - *Post-Service Claim* - In the case of an appeal of a denied post-service claim, the Appeals Administrator shall respond to you within 60 days after receipt of the appeal.

- *Pre-Service Claim* - In the case of an appeal of a denied pre-service claim, the Appeals Administrator shall respond to you within 30 days after receipt of the appeal.
- *Urgent Care Claim* - In the case of an appeal of a denied urgent care claim, the Appeals Administrator shall respond to you within 72 hours after receipt of the appeal.
- *Concurrent Care Review Claim* - In the case of an appeal of a denied concurrent care review claim, the Appeals Administrator shall respond to you before the concurrent or ongoing treatment in question is reduced or terminated.
- Notice and Information Contained in Notice Denying Appeal - If the Appeals Administrator denies your claim (in whole or in part), the Appeals Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally or via facsimile or other similarly expeditious means of communication). This notice will include the following:
 - *Reason for the Denial* - the specific reason or reasons for the denial;
 - *Reference to Plan Provisions* - reference to the specific Plan provisions on which the denial is based;
 - *Statement of Entitlement to Documents* - a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits;
 - *Description of Any Internal Rules* - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
 - *Statement of Right to Bring Action* - a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits.

The decision of the Appeals Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you challenge the decision of the Appeals Administrator, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before you can pursue the claim in federal court. Facts and evidence that become known to you after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

Notwithstanding the previous paragraph, upon exhaustion of the internal appeals procedure for benefits, you or your authorized representative may request that a denied medical claim be subject to an external review by an independent review organization designated by your Benefit Provider consistent with the applicable requirements of the Patient Protection and Affordable Care Act, as amended. For more information, contact your Benefit Provider listed in Appendix A.

CONTINUATION OF COVERAGE UNDER COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that has several provisions designed to protect you and your eligible dependents against a sudden loss of health care coverage if you have a qualifying event that would cause the loss of your health care coverage under the Plan. The following information outlines the continuation of coverage available under COBRA.

General Explanation of COBRA Continuation Coverage

COBRA requires most employers who sponsor group health care plans to provide a temporary extension of health care coverage to employees and their dependents when, due to certain circumstances, coverage would otherwise terminate under the employer's plan. This temporary extension of benefits is commonly called COBRA continuation coverage.

Individuals who are eligible for COBRA continuation coverage are called qualified beneficiaries. The events that entitle qualified beneficiaries to coverage are called qualifying events. In addition, a child born to, adopted by, or placed for adoption with the covered employee during the COBRA continuation coverage period will be a qualified beneficiary for COBRA purposes. To be a qualified beneficiary for a specific type of health coverage (*i.e.*, medical, dental or employee assistance), you must have had that particular coverage under the Plan on the day before a qualifying event occurs.

Who Must Provide Notice When Coverage is Lost

When a qualifying event occurs, you and the University have certain responsibilities. If the qualifying event is divorce or a legal separation, or loss of dependent status, you or a covered dependent must notify the Plan Administrator in writing within 60 days of the qualifying event. The University will notify the Plan Administrator if the event is death, termination of employment, reduction in hours, or entitlement to Medicare benefits.

When the Plan Administrator is notified of a qualifying event, the Plan Administrator or its designee will send you and/or your dependents a written explanation of the right to elect COBRA continuation coverage. You then have 60 days from the later of the date of this explanation from the Plan Administrator or the date on which your existing coverage would end to notify the Plan Administrator of your election. If you and/or a dependent do not respond in writing within the time limit, the right to elect COBRA continuation coverage will be lost and will not be reinstated.

The chart below summarizes who is eligible for COBRA continuation coverage under COBRA, under what circumstances, and for how long.

PERSON AFFECTED (Qualified Beneficiary)	REASON FOR LOSS OF COVERAGE (Qualifying Event)	PERIOD OF CONTINUATION COVERAGE
Employee	Reduction in hours of employment Termination of employment for reasons other than gross misconduct	18 months* 18 months*
Covered Spouse of an Employee	Death of employee	36 months
	Divorce or legal separation from employee	36 months
	Employee becomes entitled to Medicare benefits	36 months
	Reduction in employee's hours of employment	18 months*
	Termination of employee's employment for reasons other than gross misconduct	18 months*
Covered Child of an Employee	Death of employee	36 months
	Divorce or legal separation of employee and spouse	36 months
	Employee becomes entitled to Medicare benefits	36 months
	Failure of child to qualify as a dependent under the Plan	36 months
	Reduction in employee's hours of employment	18 months*
	Termination of employee's employment for reasons other than gross misconduct	18 months*

* The 18-month COBRA continuation coverage period will be extended to 29 months for all qualified beneficiaries if any qualified beneficiary is disabled under the Social Security laws at any time during the first 60 days of COBRA continuation coverage. To qualify for this extension, the qualified beneficiary must notify the Plan Administrator and provide proof that he or she is disabled under the Social Security laws before the expiration of the 18-month period. The Plan Administrator is permitted to charge a higher premium for COBRA continuation coverage during the 19th through 29th months. If the employee finds that he or she is no longer disabled, he or she must notify the Plan Administrator within 30 days of such a determination.

The 18, 29, or 36 months of COBRA continuation coverage begin on the date that coverage would originally end.

If You Elect to Continue Coverage

Each qualified beneficiary who is eligible to elect COBRA continuation coverage may make a separate election to continue coverage, or one qualified beneficiary may make an election that covers some or all of the other qualified beneficiaries.

If you elect to continue coverage, you must pay a total premium equal to the cost to the Plan of such coverage, plus a two percent (2%) monthly administration charge (or any higher charge that may be permitted by law, such as during the extended coverage on account of disability). The

total premium includes both the University's contribution and any contribution that an active participant would be required to make under the Plan for the same coverage. The first payment must be made within 45 days following the date of your election and must cover the number of full months from the date coverage ended to the time of your election. Premiums for each month after your election are due by the 1st day of the month and must be paid not later than the last day of that month. Premium rates will change periodically for all qualified beneficiaries if costs to the University change. COBRA continuation coverage will be identical to the coverage provided similarly situated employees and/or dependents. Your health care coverage will continue to be provided by the insurer, HMO, or other provider that is providing benefits to you on the date of the qualifying event (subject to any residency requirements that may apply). You will have an opportunity to change coverage options during the annual open enrollment period. Should benefit levels increase or decrease, both active and COBRA participants will experience the same change.

Coverage You May Elect

You may elect to continue Medical Coverage only, Dental Coverage only, Employee Assistance Coverage only, or any combination of these coverages. You may elect to continue only those coverages that were in effect for you on the date of your qualifying event. Since life insurance, accidental death and dismemberment insurance, long term disability insurance, short-term disability insurance, business travel accident insurance, tuition remission, tuition exchange and the Backup Care Reimbursement benefit are not health care benefits protected by COBRA, you may not elect COBRA continuation coverage of those benefits under the Plan. You may, however, have conversion rights or portability rights under certain of these insurance policies.

Coverage for Eligible Dependents

If you elect COBRA continuation coverage that also covers your eligible dependents, these dependents may not make an independent selection of coverage until the next annual open enrollment period. At that time, they may change their coverage if they wish. However, if you continue some, but not all, of the coverages to which you are entitled, or if you decide not to continue your coverage at all, each dependent may make an independent coverage selection.

Changes to COBRA Continuation Coverage

Qualified beneficiaries have the same opportunities to change coverage as active employees during each annual open enrollment period. During each annual open enrollment period, you may elect different coverage or add or delete dependents in the same manner as an active employee.

If You Have Region-Specific Coverage

If you are enrolled in a region-specific coverage option (such as an HMO) on the day before your qualifying event occurs, you may elect COBRA continuation coverage. However, you must remain in that coverage until the next annual open enrollment period, at which time you may change coverage if you so wish. If you move out of the service area during your period of COBRA continuation coverage, you may be able to elect alternate coverage.

When COBRA Benefits End

Generally, COBRA continuation coverage runs for 18, 29 or 36 months, depending on the qualifying event, as described in the chart above. However, COBRA continuation coverage will end immediately if:

- The person whose coverage is being continued fails to pay the premium on time;
- The person whose coverage is being continued becomes, after the date of the election of COBRA continuation coverage, covered under another employer's group health plan unless the other group health plan contains an exclusion or limitation with respect to a preexisting condition of the person (other than an exclusion or limitation that does not apply to (or is satisfied by) the person under applicable provisions of federal law);
- The person whose coverage is being continued becomes, after the date of the election of COBRA continuation coverage, entitled to Medicare benefits;
- In the case of a person whose coverage is being continued under the special extended coverage period for disabled individuals, it is determined that the disabled person is no longer disabled under the Social Security laws; or
- The University no longer maintains a group health plan covering any employee.

Two Qualifying Events

An 18-month period of COBRA continuation coverage may be extended if another qualifying event occurs during that time. However, no one may extend coverage for more than 36 months from the occurrence of the first qualifying event. For example, if your employment ends and you get divorced during the initial 18-month continuation period, your dependents (but not you) may extend coverage for up to 36 months from the date your employment ended. If the covered employee becomes entitled to Medicare benefits and during the subsequent 18-month period loses coverage due to a termination of employment (for reasons other than gross misconduct) or a reduction in hours of employment, all qualified beneficiaries other than the employee will be entitled to a maximum of 36 months of coverage from the date of Medicare entitlement, subject to the rules regarding earlier termination of COBRA coverage.

Continuation Coverage During Military Service

Employees and dependents who lose health coverage due to the employee's military leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 may elect to continue coverage for up to 24 months. If the employee performs military service for fewer than 31 days, he or she cannot be required to pay more than the regular employee share of premium payments for health care coverage. If the employee performs military service for 31 or more days, he or she cannot be required to pay more than the premium payment of a COBRA qualified beneficiary.

Conversion to an Individual Policy

At the end of the 18, 29, or 36-month COBRA continuation coverage period, you may be eligible to convert your coverage to an individual policy. If you are eligible, you will be required to make the necessary arrangements directly with the insurance carriers. The necessary information should be contained in the materials provided by the insurance carriers. If not, you should check with your Human Resources benefit representative. Conversion coverage may not be the same as the coverage you have under the Plan. Instead, it will be one of the insurance carrier's standard conversion policies.

PLAN ADMINISTRATOR

Within the meaning of ERISA, the Plan Administrator is Villanova University; provided, that the University may appoint an individual or a committee to act as Plan Administrator. The name, business address, and business telephone number of the Plan Administrator are provided under the section below entitled ADDITIONAL INFORMATION.

In general, the Plan Administrator is the sole judge of the application and interpretation of the Plan, and has the discretionary authority to construe the provisions of the Plan, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits. However, the Plan Administrator has the authority to delegate certain of its powers and duties to a third party. The Plan Administrator has delegated certain administrative functions under the Plan to various service providers. As the Plan Administrator's delegate, these service providers have the authority to make decisions under the Plan relating to benefit claims, including determinations as to the medical necessity of any service.

The decisions of the Plan Administrator (or its delegate) in all matters relating to the Plan (including, but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) will be final and binding on all parties and generally will not be overturned by a court of law.

AMENDMENT OR TERMINATION OF THE PLAN

The University (acting through the Vice President for Administration and Finance of the University or through an individual appointed by the Vice President) reserves the right to amend or modify the Plan at any time and for any reason with respect to both current and former employees and their dependents. Such changes may include, but are not limited to, the right to (1) change or eliminate benefits/coverages, (2) increase or decrease employee contributions, (3) increase or decrease deductibles and/or copayments and/or any applicable maximums, (4) change the class(es) of employees and/or dependents covered by the Plan, (5) change insurers, HMOs, third party administrators or other providers, and (6) change the funding mechanism for certain benefits from self-insured to fully insured. The University also reserves the right to terminate the Plan, or any portion of the Plan, at any time and for any reason. No amendment, termination or partial termination of the Plan will affect claims incurred for which items or services have been provided prior to the date of amendment, termination or partial termination.

ADDITIONAL INFORMATION

Plan Information. The official Plan name, Plan identification number, and Plan Year (fiscal year used for Plan records) for the Plan are as follows:

Plan Name: Villanova University Health and Welfare Plan

Plan Number: 501

Plan Year: The 12-month period commencing on June 1 and ending each May 31.

University/Plan Sponsor Information. The name, address and telephone number of the University/Plan Sponsor are as follows:

Villanova University
800 Lancaster Avenue
Villanova, PA 19085-1699
610-519-7900

Employer Identification Number (“EIN”). The employer identification number assigned to the University by the IRS is 23-1352688.

Plan Administrator Information. The name, address and telephone number of the Plan Administrator are as follows:

Villanova University
800 Lancaster Avenue
Villanova, PA 19085-1699
610-519-7900

Agent for Service of Legal Process. The agent for the service of legal process for the Plan is the University/Plan Sponsor, at the address set forth above.

Type of Plan. The Plan is a welfare benefit plan providing the following types of benefits: (1) medical coverage, (2) dental coverage, (3) EAP, (4) life insurance (basic and AD&D, additional life), (5) dependent life insurance, (6) long term disability insurance, (7) short term disability benefits, and (8) business travel accident insurance. The benefits described in items (1), (2), and (3) are provided under a “group health plan” within the meaning of ERISA. The Plan also provides tuition, health advocacy, commuter and child care benefits.

Administration. Benefits under the Plan are administered by various providers in accordance with contracts the University has entered into with various insurance companies, HMOs, and other providers or administrators of health and welfare benefits, or directly by the University. A list of providers and their roles under the Plan is included in Appendix A.

Funding Medium. The benefits under the Plan are funded through direct payments from the general funds of the Plan Sponsor or one or more insurance contracts. The University establishes contribution rates based upon premium rates set by the insurance carriers and/or administrators.

Contributions are made by employees, COBRA qualified beneficiaries, and the University. Periodically, dividends or refunds are received from the insurance carriers or administrators. These will be used to reduce University expenses.

THIRD PARTY LIABILITY

If your injury or illness was caused by the action or inaction of another person or party, that person or party may be responsible for your hospital or medical bills. Automobile accident injuries or personal injury suffered on another's property are examples.

Since collecting payments for these expenses from the third party may take a long time, the Plan will provide the appropriate benefits and then seek repayment from any settlement you may receive. You may be asked to sign a form that acknowledges the Plan's right to be reimbursed and verifies that you will help the Plan secure its rights to reimbursement or recovery. If you bring a liability claim against a third party, benefits payable under the Plan must be included in the claim. When the claim is resolved, you must reimburse the Plan for the cost of the benefits provided. The Plan will have first priority in any recovery regardless of the manner in which the recovery is structured or worded and regardless of whether you have been "made whole" by the settlement. Attorney's fees will not reduce the Plan's reimbursement, unless agreed to by the Plan. Any so-called "fund doctrine" or "common fund doctrine" or "attorney's fund doctrine" shall not defeat the right of the Plan to recover under this section without paying attorney's fees or costs. Further, the Plan will not recognize any attempt to apply the "collateral source" rule or the "common fund" rule as legal theories intended to prevent or limit the Plan's recovery from any payment you may receive from a third party.

You are legally obligated to avoid doing anything that would prejudice the Plan's rights of reimbursement. However, the Plan shall be entitled to recover in accordance with these rules, even if you do not sign or return its forms. Your failure to cooperate may result in your disqualification from receipt of further benefits from the Plan. In addition, the Plan may offset any future benefits otherwise payable.

This provision does not apply to an individual insurance policy covering you or your dependents for which you or your dependent paid the premium.

NO ASSIGNMENT OF BENEFITS

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void. The payment of benefits directly to a health care provider, if any, shall be done as a convenience to the covered person and will not constitute an assignment of benefits under the Plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDER ("QMCSO")

If a qualified medical child support order (QMCSO) issued in a domestic relations proceeding (e.g., a divorce or legal separation proceeding) requires you as a parent to cover a child who is not in your custody, you may do so. To be qualified, a medical child support order must include:

- name and last known address of the parent who is covered under this Plan;

- name and last known address of each child to be covered under this Plan;
- type of coverage to be provided to each child; and
- period of time the coverage is to be provided.

QMCSOs should be sent to the Plan Administrator. Upon receipt, the Plan Administrator will notify you and describe the Plan's procedures for determining if the order is qualified. If the order is qualified, you may cover your children under the Plan. As a beneficiary covered under the Plan, your child will be entitled to information that the Plan provides to other beneficiaries under ERISA's reporting and disclosure rules. You may receive from the Benefit Providers listed in Appendix A, without charge, a copy of the Plan's QMCSO procedures.

STATEMENT OF ERISA RIGHTS

IMPORTANT: The following information does not apply to the coverage under Tuition Remission, Tuition Exchange, the Backup Care Reimbursement Program, Health Advocacy Program or the Commuter Benefit Plan as these benefits are not subject to the Employee Retirement Income Security Act of 1974.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("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, 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 SPD. 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.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, 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 materials 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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should happen that the Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if 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, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Villanova University herewith causes this Plan to be executed as of the 28 day of May, 2014 by its duly authorized officer.

VILLANOVA UNIVERSITY

By: Kenneth G. Valosky
Kenneth G. Valosky
Vice President for
Administration and Finance

**APPENDIX A
BENEFIT PROVIDERS
(As of June 2014)**

Medical Coverage

Value Personal Choice Flex Plan (PPO)
Independence Blue Cross
1901 Market Street
Philadelphia, PA 19103-1480

Premium Personal Choice Flex Plan (PPO)
Independence Blue Cross
1901 Market Street
Philadelphia, PA 19103-1480

Keystone HMO
Independence Blue Cross
1901 Market Street
Philadelphia, PA 19103-1480

The University has contracted with the above insurance company to provide medical benefits and claims services under the Plan. Benefits are self-insured and are not guaranteed by the insurance company.

Prescription Drug Coverage

Express Scripts Inc.
225 Summit Avenue
MVL1-3
Montvale, NJ 07645
1-201-269-3431

The University has contracted with the above insurance company to provide prescription drug and claims services under the Plan. Benefits are self-insured and are not guaranteed by the insurance company.

Dental Coverage

Delta Dental of Pennsylvania
One Delta Drive
Mechanicsburg, PA 17055-6999
1-800-932-0783

The University has contracted with the above insurance company to provide dental benefits and claims services under the Plan. Benefits are self-insured and are not guaranteed by the insurance company.

EAP Coverage

Health Advocate
3043 Walton Road
Plymouth Meeting, PA 19462
1-866-799-2728

The University has contracted with the above provider to provide EAP benefits and claims services under the Plan. Benefits are determined and paid entirely by the provider and are guaranteed under the agreement.

Health Advocacy Coverage

Health Advocate
3043 Walton Road
Plymouth Meeting, PA 19462
1-866-799-2728

The University has contracted with the above provider to provide Health Advocacy benefits and claims services under the Plan. Benefits are determined and paid entirely by the provider and are guaranteed under the agreement.

Long-Term Disability Coverage

UNUM Benefits Administration
2211 Congress Street
P.O. Box 9500
Portland, ME 04122
1-800-421-0344

The University has contracted with the above insurance company to provide long-term disability benefits and claims services under the Plan. Benefits are determined and paid entirely by the insurance company and are guaranteed under the policy.

Life and Accident Coverage

UNUM Benefits Administration
2211 Congress Street
P.O. Box 9500
Portland, ME 04122
1-800-421-0344

The University has contracted with the above insurance company to provide life and accident benefits and claims services under the Plan. Benefits are determined and paid entirely by the insurance company and are guaranteed under the policy.

Business Travel Accident Coverage

Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, PA 19192

1-610-758-7753

The University has contracted with the above insurance company to provide business travel accident coverage and claims services under the Plan. Benefits are determined and paid entirely by the insurance company and are guaranteed under the policy.

Short-Term Disability Coverage

UNUM Benefits Administration
2211 Congress Street
P.O. Box 9500
Portland, ME 04122
1-800-421-0344

The University has contracted with the above insurance company to administer short-term disability benefits and benefits are paid from the general assets of the University.

Backup Care Reimbursement Benefit

Health Advocate
3043 Walton Road
Plymouth Meeting, PA 19462
1-866-799-2728

The University has contracted with the above third-party administrator to provide administrative and claims services under the Plan. Benefits are self-insured and are not guaranteed by Health Advocate.

Commuter Benefit Plan

WageWorks
P.O. Box 14053
Lexington, KY 40511
1-877-924-3967

The University has contracted with the above third-party administrator to provide administrative services under the Plan.

APPENDIX B
CLAIMS ADMINISTRATORS AND APPEALS ADMINISTRATORS
(As of June 2014)

TYPE OF BENEFIT/PROVIDER	NAME AND ADDRESS OF CLAIMS ADMINISTRATOR	NAME AND ADDRESS OF APPEALS ADMINISTRATOR
Medical		
Value Personal Choice Flex Plan (PPO)	Personal Choice Independence Blue Cross P.O. Box 890016 Camp Hill, PA 17089-0016	IBC Member Appeals Unit P.O. Box 41820 Philadelphia, PA 19101-1820
Premium Personal Choice Flex Plan (PPO)	Personal Choice Independence Blue Cross P.O. Box 890016 Camp Hill, PA 17089-0016	IBC Member Appeals Unit P.O. Box 41820 Philadelphia, PA 19101-1820
Keystone HMO	Keystone HMO Independence Blue Cross P.O. Box 898815 Camp Hill, PA 17089-8815	KHPE Member Appeals Unit P.O. Box 41820 Philadelphia, PA 19101-1820
Prescription Drug		
Express Scripts	Express Scripts Inc. 225 Summit Avenue MVL1-3 Montvale, NJ 07645	Express Scripts Inc. 225 Summit Avenue MVL1-3 Montvale, NJ 07645
Dental		
Delta Dental	Delta Dental of Pennsylvania One Delta Drive Mechanicsburg, PA 17055-6999	Delta Dental of Pennsylvania One Delta Drive Mechanicsburg, PA 17055-6999
Employee Assistance		
Health Advocate	Health Advocate 3043 Walton Road Plymouth Meeting, PA 19462 1-866-799-2728	Health Advocate 3043 Walton Road Plymouth Meeting, PA 19462 1-866-799-2728
Long-Term Disability		
UNUM	UNUM Benefits Administration 2211 Congress Street P.O. Box 9500 Portland, ME 04122	UNUM Benefits Administration 2211 Congress Street P.O. Box 9500 Portland, ME 04122

Life and Accident		
UNUM	UNUM Benefits Administration 2211 Congress Street P.O. Box 9500 Portland, ME 04122	UNUM Benefits Administration 2211 Congress Street P.O. Box 9500 Portland, ME 04122
Business Travel Accident		
Life Insurance Company of America	Life Insurance Company of America 1601 Chestnut Street Philadelphia, PA 19192	Life Insurance Company of America 1601 Chestnut Street Philadelphia, PA 19192
Short-Term Disability		
UNUM	UNUM Benefits Administration 2211 Congress Street P.O. Box 9500 Portland, ME 04122	UNUM Benefits Administration 2211 Congress Street P.O. Box 9500 Portland, ME 04122
Backup Care Reimbursement Benefit		
Health Advocate	Health Advocate 3043 Walton Road Plymouth Meeting, PA 19462 1-866-799-2728	Health Advocate 3043 Walton Road Plymouth Meeting, PA 19462 1-866-799-2728
Health Advocacy Benefit		
Health Advocate	Health Advocate 3043 Walton Road Plymouth Meeting, PA 19462 1-866-799-2728	Health Advocate 3043 Walton Road Plymouth Meeting, PA 19462 1-866-799-2728
Commuter Benefit Plan		
WageWorks	WageWorks P.O. Box 14053 Lexington, KY 40511	WageWorks P.O. Box 14053 Lexington, KY 40511

APPENDIX C

HIPAA PRIVACY & PROTECTED HEALTH INFORMATION

The Plan is a hybrid entity for purposes of HIPAA. As such, the portion of the Plan that provides medical, dental, and employee assistance benefits is part of the health care component. The portion of the Plan that provides short-term disability, long-term disability, life and accident insurance, business travel accident coverage, health advocacy benefits, tuition remission coverage and tuition exchange benefits is part of the non-health care component. References to the "Plan" in this section refer only to the health care component of the Plan, including any health insurance issuer or HMO that provides medical benefits pursuant to the Plan.

The following provisions permit the Plan to disclose your protected health information ("PHI"), as defined in HIPAA, to the Plan Sponsor to the extent that such PHI is necessary for the Plan Sponsor to carry out its administrative functions related to the Plan. This Appendix C is effective April 14, 2004.

Disclosure To The Plan Sponsor. The Plan (or health insurance issuer or HMO with the Plan's permission) may disclose your PHI to the Plan Sponsor that is necessary for the Plan Sponsor to carry out the following administrative functions related to the Plan.

The Plan Sponsor needs access to PHI to:

- Determine whether you and/or your dependent are eligible for benefits under the Plan;
- Determine the amount of benefits, if any, you and/or your dependent are entitled to from the Plan;
- Determine or find facts that are relevant to any claim for benefits from the Plan;
- Determine whether a participant's benefits should be terminated or suspended;
- Perform duties relating to the establishment, maintenance and administration of the Plan;
- Communicate with participants regarding the status of their claims;
- Recover any overpayment or mistaken payments made to claimants; and
- Handle participant issues with regard to subrogation and third party claims.

The Plan Sponsor may use and disclose your PHI provided to it from the Plan (or health insurance issuer or HMO) only for the administrative purposes described above.

Limitations And Requirements Related To The Use and Disclosure of PHI: The Plan Sponsor agrees to the following limitations and requirements related to its use and disclosure of your PHI received from the Plan:

- (a) Use and Further Disclosure. The Plan Sponsor will not use or further disclose your PHI other than as permitted or required by this document or as required by law. When using or disclosing your PHI or when requesting your PHI from the Plan, the Plan Sponsor will make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.
- (b) Agents and Subcontractors. The Plan Sponsor will require any agents, including subcontractors, to whom it provides your PHI received from the Plan to agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.
- (c) Employment-Related Actions and Decisions. Except as permitted by HIPAA and other applicable law, the Plan Sponsor will not use your PHI to take employment-related actions or make employment-related decisions about you, or in connection with any other employee benefit plan of the Plan Sponsor.
- (d) Reporting of Improper Use or Disclosure. The Plan Sponsor shall promptly report to the Plan any improper use or disclosure of your PHI of which it becomes aware.
- (e) Adequate Protection. The Plan Sponsor will provide adequate protection of your PHI and separation between the Plan and the Plan Sponsor by:
 - (1) ensuring that only the minimum necessary number of employees will have access to your PHI provided by the Plan;
 - (2) restricting access to and use of your PHI to only the minimum necessary number of employees and only for the administrative functions performed by the Plan Sponsor on behalf of the Plan that are described above;
 - (3) requiring any agents of the Plan who receive your PHI to abide by the Plan's privacy rules; and
 - (4) using the following procedure to resolve issues of noncompliance by the employees identified above:
 - (a) The Plan will be immediately notified, and the Plan and Plan Sponsor will work together to remedy the situation and mitigate any harmful effect resulting from the use or disclosure of PHI;
 - (b) After an investigation into the alleged incident, those employees who are found to be in violation of these policies or the HIPAA Privacy Regulations will be sanctioned as is deemed appropriate; and
 - (c) The Plan and Plan Sponsor will work together to create new safeguards and procedures so as to prevent a future incident of noncompliance.
- (f) Breach of Unsecured Protected Health Information. Upon the discovery of a potential breach of PHI, the Plan Sponsor will determine whether the incident is an actual breach

under the Health Information for Economic and Clinical Health Act (“HITECH”) and comply with the timing, content and other breach notification requirements of HITECH. The Plan Sponsor shall take appropriate measures to mitigate any harm that has resulted or may result from the breach and to prevent such a breach from occurring in the future.

- (g) Return or Destruction of PHI. If feasible, the Plan Sponsor will return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- (h) Participant Rights. The Plan Sponsor will provide you with the following rights:
 - (1) the right to access to your PHI;
 - (2) the right to amend your PHI upon request (or the Plan Sponsor will explain to you in writing why the requested amendment was denied) and incorporate any such amendment into your PHI; and
 - (3) the right to an accounting of all disclosures of your PHI.
- (i) Cooperation with HHS. The Plan Sponsor will make its books, records, and internal practices relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for verification of the Plan’s compliance with HIPAA.

Certification: The Plan will disclose PHI to the Plan Sponsor only upon receipt of a Certification by the Plan Sponsor that this Plan document has been amended in accordance with HIPAA, and that the Plan Sponsor will protect the PHI as described above.