

**University of Richmond
Employee Welfare Benefits Plan**

**Plan Document and
Summary Plan Description**

Restated as of January 1, 2020

University of Richmond reserves the right to amend this Plan at any time or from time-to-time without the consent of or, to the extent permitted by law, prior notice to any employee or participant. Although University of Richmond expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan or any Plan benefit option, feature or component at any time without liability.

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INTRODUCTION

We are pleased to provide you with this Plan Document and Summary Plan Description (“SPD”) summarizing the University of Richmond Employee Welfare Benefits Plan (the “Plan”) sponsored by University of Richmond (the “University”) for eligible employees and their eligible dependents.

The Plan is composed of the following benefit programs (“Component Programs”):

<u>Attachment</u>	<u>Component Program</u>
1, 2 and 3	Medical, including active medical, Pre-65 retiree medical, vision, and prescription drug benefits (“Medical Plan”)
4	Voluntary Dental Insurance (“Dental Plan”)
5 and 6	Basic Life and Accidental Death & Dismemberment Insurance (“Life and AD&D Plan”)
7	Long-Term Disability Insurance Plan (“LTD Plan”)
8	Short-Term Disability Plan for Faculty and Staff (“STD Plan”)
9	Employee Assistance Program (“EAP”)
10	Pre-65 Retiree Medical Benefits Program and Post-Retirement Medical Benefits Program, which includes a Medicare supplement insurance plan and a Medicare Part D prescription drug plan
11	Closed Retiree Medical Benefits Program
12	Disabled Employee Medicare Supplement Plan
13	Voluntary Supplemental Life Insurance Program (“Voluntary Life Insurance Program”)
14	Voluntary Vision Plan (“Voluntary Vision Plan”)
15	Flexible Benefits Plan, including the Premium Conversion feature, the Medical Flexible Spending Account (“Medical FSA”), the Dependent Care FSA, and the Health Savings Account (“HSA”) (“Flex Plan”)
16	University of Richmond Group Legal Services Plan (“Legal Resources”)
17	Voluntary Accidental Injury Insurance (“Voluntary Injury Insurance”)
18	Voluntary Hospital Indemnity Insurance (“Voluntary Hospital Insurance”)

A summary of each Component Program provided under the Plan is set forth in the benefit booklet, certificate of insurance, or other governing document identified in Attachments #1-17.

This document, together with Attachments #1-17, and their respective policies, descriptions and other materials (either written or electronic), constitute the written plan and the summary plan description to the extent required by Section 102 of the Employee Retirement Income Security Act of 1974 (“ERISA”) and regulations thereunder, and Section 125 of the Internal Revenue Code of 1986, as amended (the “Code”) for the Plan. This document also summarizes certain terms of the Dependent Care FSA, the HSA, the Voluntary Vision Plan, the Voluntary Life Insurance Program, the STD Plan, Voluntary Injury

Insurance, and Voluntary Hospital Insurance. The Dependent Care FSA, the HSA, and the STD Plan are not employee benefit plans covered under ERISA.

The policies, contracts or booklets for each Component Program govern the benefits to be provided and include more details on how the Component Programs operate. If there is any conflict between this document and such policies, contracts or booklets, then such other documents will control unless otherwise required by law or specified in this Plan document. Participants and beneficiaries should not rely on any oral description of the Plan because the written terms of the Plan will always govern.

GENERAL INFORMATION ABOUT THE PLAN

This section contains general information that you may need to know about the Plan.

Plan Name

University of Richmond Employee Welfare Benefits Plan

Plan Number

The University has assigned Plan Number 511 to the Plan.

Effective Dates

This Plan document and SPD are effective as of January 1, 2020.

Plan Year

The Plan Year is January 1 – December 31.

Plan Sponsor

University of Richmond
28 Westhampton Way
University of Richmond, VA 23173
Telephone Number: (804) 289-8000
E.I.N.: 54-0505965

Plan Administrator

Director, Compensation & Benefits
Human Resources
University of Richmond
112 Weinstein Hall
University of Richmond, VA 23173
Telephone Number: (804) 289-8747

The Plan Administrator has delegated certain day-to-day administration of the Plan and claims fiduciary responsibility for the processing and review of claims for benefits under the Plan, including COBRA claims and administration, to the third-party administrators and claims administrators listed in Schedule A. The Plan Administrator will also answer any questions you may have about the Plan.

Service of Legal Process

The name and address of the Plan's agent for service of legal process is:

General Counsel
University of Richmond
28 Westhampton Way
University of Richmond, VA 23173

Service of legal process may also be made upon the Plan Administrator. Service for the third-party administrators, claims administrators and COBRA Administrator may be made at the addresses provided in Schedule A.

Type of Plan

The Plan, except for the Dependent Care FSA, the HSA, and the STD Plan, is intended to be an "employee welfare benefit plan" within the meaning of ERISA Section 3(1).

The Plan is also intended, in part, to be a "cafeteria plan" within the meaning of Section 125 of the Code.

The Medical FSA is intended to qualify as a qualified benefits plan that is a health care flexible spending arrangement as defined under Section 106(c)(2) of the Code and Proposed Treasury Regulation Section 1.125-5. The benefits provided thereunder are intended to be eligible for exclusion from income to the extent provided under Sections 105(b), 106 and 125(a) of the Code, as applicable.

The Dependent Care FSA is intended to qualify as a dependent care assistance program under Section 129 of the Code. The benefits provided thereunder are intended to be eligible for exclusion from income under Sections 125(a) and 129(a) of the Code.

Type of Administration and Funding

Benefits furnished hereunder are provided through the purchase of insurance policies and contracts, unless otherwise indicated in Schedule A. The University will collect employee premiums and will pay when due all premiums required to keep such policies and contracts in force. Funding is derived from the funds of the University and contributions made by the employees. The level of any employee contributions is set by the University and will be communicated to employees prior to any initial, open, or special enrollment period. Employee contributions will be used in funding the cost of the Plan benefits as soon as practicable after they have been received from the employee or withheld from the employee's pay through payroll deduction.

ELIGIBILITY

Employee Eligibility

Subject to any additional eligibility requirements for a Component Program that are set forth in the plan documents identified in the Attachments, all full-time employees of the University who are regularly scheduled to work at least 1,511 hours per calendar year (or 75% time) and any faculty enrolled in the Faculty Phased Retirement Program are eligible to participate in the Plan. In addition, all employees of the University, regardless of full-time or part-time status, are eligible to participate in the EAP. Notwithstanding the foregoing, employees in the following categories are not eligible to participate in the Plan (except as provided under “Medical Plan Eligibility,” below):

- leased employees;
- individuals who are classified by the University as temporary workers, interns, co-ops, independent contractors or consultants; or
- individuals from whom the University does not withhold federal income and employment taxes from such person’s compensation.

Note that all employees of the University (except for employees in the three categories listed above) are eligible to participate in the EAP.

Notwithstanding anything contained herein to the contrary, any individual who is classified as a “leased employee,” “temporary worker,” “intern,” “co-op,” “independent contractor,” or “consultant,” or similar classification by the University (which status may be evidenced by the payroll practices or records of the University, or by a written or oral agreement or arrangement with the individual or with another organization that provides the services of the individual to the University, under which the individual is treated as an independent contractor or is otherwise treated as an employee of an entity other than the University (such as a leasing organization)), is not eligible to participate in the Plan during the period so classified, irrespective of (i) whether the individual is considered an employee of the University under common law employment principles; (ii) whether such characterization is subsequently challenged, changed or upheld by the University or any court or governmental authority, including, without limitation, an individual classified by the University as a “leased employee” (as described in Code Section 414(n)); and (iii) how such individual may be treated by the University for other purposes (such as employment tax purposes).

Medical Plan Eligibility

An employee is eligible to participate in the Medical Plan Option if he or she

- is regularly scheduled to work at least 1,511 hours per calendar year;
- is a faculty member enrolled in the Faculty Phased Retirement Program;
- worked at least 30 “Hours of Service” per week on average during the “Standard Measurement Period” that ended immediately before the current Plan Year; or
- worked at least 30 “Hours of Service” per week, on average during his or her first 12 months of employment with the University.

More information about Medical Plan Option eligibility is provided in the Medical Plan Option Eligibility Appendix.

Dependent Eligibility

Subject to the eligibility requirements set forth below for a specific Component Program, you may enroll the following members of your family in the Plan (“Eligible Dependents”):

- **Your spouse.** “Spouse” means the individual to whom you are legally married under the law of any domestic or foreign jurisdiction having the legal authority to sanction marriages. You may be required to provide proof that an individual is your spouse in accordance with such procedures as may be established by the Plan Administrator from time to time. The Plan Administrator shall have the sole discretion to determine the legal status of a marriage. The term spouse shall not include an individual with whom you have entered into a registered domestic partnership, civil union, or other similar formal relationship recognized under state law that is not denominated as a marriage under the laws of that state.

- **Your Children.** “Children” means:
 - Each of your children through the end of the calendar year in which he or she turns 26. Your child is eligible regardless of whether he or she is married or unmarried, regardless of his or her student or employment status, regardless of whether your home is his or her principal place of abode, and regardless of whether you support him or her financially; and
 - Each of your children who (i) is age 26 or more, (ii) was physically or mentally disabled prior to attaining age 26, (iii) is unmarried, (iv) was covered under the Plan immediately prior to attaining age 26, (v) is incapable of self-sustaining employment by reason of a mental or physical disability, (vi) is primarily supported by you, and (vii) is allowed to be claimed by you as an exemption for federal income tax purposes.
 - For purposes of this definition, “child” or “children” includes the following: your biological children, your stepchildren, your legally adopted children, your foster children, any children placed with you for adoption, any children for whom you are responsible under court order, and children for whom you are appointed legal guardianship, and any children for whom you are responsible to provide medical coverage under a Qualified Medical Child Support Order.

EAP

For purposes of the EAP, in addition to the above individuals, any additional members of your household will be Eligible Dependents.

Medical FSA

For purposes of the Medical FSA and the premium conversion feature of the Flex Plan, your Eligible Dependent may also include any individual who is a tax dependent of yours as defined in Section 152 of

the Code (determined without regard to Sections 152(b)(1), (b)(2) or (d)(1)(B)). If you enroll in the High Deductible Health Plan option under the Medical Plan Option, you are not eligible for the Medical FSA.

Dependent Care FSA

For purposes of the Dependent Care FSA, your dependent is any individual who is your “qualifying child,” your “qualifying relative” or your spouse who is physically and mentally incapable of caring for himself or herself and who lives with you for more than half of the calendar year.

- A “qualifying child” generally includes someone who:
 - bears a familial relationship to you (e.g., a child or stepchild, sibling, or step-sibling, or a descendant of any such relative),
 - lives with you for more than half of the calendar year,
 - does not provide more than one-half of his or her own support for the calendar year, and
 - has not reached age 13 or is permanently and totally disabled at any time during the calendar year.

- A “qualifying relative” generally includes someone who:
 - bears a familial relationship to you (e.g., a child or stepchild, sibling or step-sibling, parent or step-parent, grandparent, niece, nephew, in-law) or is a member of your household (excluding an individual who is your spouse at any time during the taxable year),
 - is mentally and physically incapable of self-care,
 - lives with you for the entire calendar year,
 - does not provide more than one-half of his or her support for the calendar year, and is not a qualifying child of you or any other taxpayer for the calendar year.

Voluntary Life Insurance Program

For purposes of the Voluntary Life Insurance Program, your new-born child will become an Eligible Dependent on the date that the child is 14 days old.

Retiree Medical Benefits

Eligible Dependents generally will be eligible for and covered under the Pre-65 Retiree Medical Benefits Program in accordance with the Dependent Eligibility rules set forth in the preceding paragraphs if you are eligible for and enrolled in the Pre-65 Retiree Medical Benefits Program. Your Eligible Dependents may be covered under the Pre-65 Retiree Medical Benefits Program only if you enroll them when you enroll in the Pre-65 Retiree Medical Benefits Program. Your spouse will be eligible for and covered under the Post-Retirement Medical Benefits Program only if they were covered under the Medical Plan at the time of your retirement, with any of your children who were covered

under the Medical Plan at the time of your retirement remaining covered under the Medical Plan until the end of the calendar year in which they attain age 26.

Legal Resources

For purposes of Legal Resources, your children who do not reside with you are not Eligible Dependents. Your widow/widower and any children who are enrolled in Legal Resources at the time of your death are Eligible Dependents for certain matters. Please see the benefit booklet referenced at Attachment #17 for more information.

NOTE: If you apply for or continue coverage for anyone who is not an Eligible Dependent, you may be guilty of fraud or intentional misrepresentation and this individual's coverage may be rescinded, to the extent permitted by law. You may also be subject to discipline up to and including termination of employment. In addition, if the Plan expends funds for coverage of ineligible individuals, you may be liable for premiums and all costs related to coverage for such individuals who are not Eligible Dependents.

Retiree Eligibility

The University offers retiree medical benefits to certain early retirees and to certain retirees once they reach age 65. The eligibility requirements for each of these benefits are set forth below. See the document referenced at Attachment #11 for information regarding the Pre-65 Retiree Medical Benefits Program and the Post-Retirement Medical Benefits Program, and the document referenced at Attachment #12 for information regarding the Closed Retiree Medical Benefits Program.

Pre-65 Retirees

Full-time tenured faculty members of the University are eligible for the Pre-65 Retiree Medical Benefits Program if they retire after attaining age 59½ and completing 20 years of service with the University pursuant to the University of Richmond Early Retirement Plan for Tenured Faculty. A faculty member's eligibility for the Pre-65 Retiree Medical Benefits Program is governed by the University of Richmond Early Retirement Plan for Tenured Faculty and dependent upon the faculty member's election to participate in that plan in accordance with its terms.

Full-time staff employees and continuing faculty of the University are eligible for the Pre-65 Retiree Medical Benefits Program if they retire pursuant to the University of Richmond Early Retirement Plan for Staff Employees between the ages of 60 and 65 and, at the time of retirement, have a combined age and years of employment that equal or exceed 80. A staff employee's eligibility for the Pre-65 Retiree Medical Benefits Program is governed by the University of Richmond Early Retirement Plan for Staff Employees and dependent upon the staff employee's election to participate in that plan in accordance with its terms.

Early retirees who become covered under the Pre-65 Retiree Medical Benefits Program, and their covered dependents, must waive their rights to COBRA continuation coverage based upon their termination of employment.

Retirees Age 65 or Older

Open Plan

Except as explained in the next paragraph, full-time faculty members who were hired prior to September 1, 2003 and full-time staff employees who were hired on or prior to July 1, 1992 and have been continuously employed since their hire date are eligible to participate in the Post-Retirement Medical Benefits Program. If you are eligible for the Post-Retirement Medical Benefits Program and covered under the Pre-65 Retiree Medical Benefits Program or still actively working, you will be automatically enrolled in the Medicare supplement insurance plan but you will need to apply for the Medicare Part D prescription drug plan. If you are eligible for the Post-Retirement Medical Benefits Program but you are not actively working (*i.e.*, you are a disabled employee who is covered under the Disabled Employee Medicare Supplement Plan) or covered under the Pre-65 Retiree Medical Benefits Program, **then you must notify the Plan Administrator at least 3 months prior to your 65th birthday that you want to enroll in the Post-Retirement Medical Benefits Program.** If you fail to notify the Plan Administrator prior to your 65th birthday that you want to enroll in the Post-Retirement Medical Benefits Program, then you will not be eligible for the Post-Retirement Medical Benefits Program.

Closed Plan

Full-time tenured faculty members who either retired by December 31, 1993 or who were qualified to and entered into an agreement to early retire by March 31, 1993 and full-time staff employees who retired by December 31, 1993 are eligible to participate in the Closed Retiree Medical Benefits Program.

Disabled Employee Eligibility

You are eligible to participate in the Disabled Employee Medicare Supplement Plan if you meet the following three requirements: (1) you are receiving benefits pursuant to the Long-Term Disability Insurance Plan; (2) you are eligible for Social Security disability benefits and Medicare; and (3) you notify the Plan Administrator that you would like to enroll in the Disabled Employee Medicare Supplement Plan within 30 days after the date on which you receive notification that you have been approved for Medicare. See the document referenced at Attachment #13 for information regarding the Disabled Employee Medicare Supplement Plan.

ENROLLMENT

General

You are automatically enrolled in the EAP upon becoming eligible. You may elect to participate in the various other Component Programs available under the Plan by complying with the enrollment procedures established by the Plan Administrator with respect to each Component Program as in effect from time to time. These procedures may include, but are not limited to, completing and filing with the University an enrollment form authorizing payroll deductions of your compensation from the University or completing an online enrollment process.

During each annual open enrollment, you must elect your desired Plan benefits for the following year. However, to the extent that you do not participate in an annual open enrollment period, except as set forth in any material provided to you in connection with that annual open enrollment period, your current benefit elections will continue unchanged during the following year. The foregoing sentence does not apply to Medical FSA, and Dependent Care FSA, you must actively elect the amount of your contributions under these Component Plans every year.

In order to enroll your Eligible Dependents in any Component Program, you must also enroll in that Component Program yourself. You may be required to verify the eligibility of your Eligible Dependents for coverage (e.g., by providing a birth or marriage certificate). If you fail to timely provide the documentation upon request to prove the eligibility of any of your Eligible Dependents or if the Plan Administrator (or its delegate) is unable to verify the submitted documentation, your dependent (or dependents) will lose coverage under the Component Program, whether or not he or she (they) is (are) otherwise eligible for benefits under that program.

If you have other medical coverage that you prefer to the Medical Plan, then you may waive enrollment in the Medical Plan. To waive Medical Plan coverage, you must complete a Benefits Enrollment/Change form found at <https://hr.richmond.edu/forms/benefit-change-form.pdf> and provide proof of your other coverage to the University. If you properly waive Medical Plan coverage within thirty-one (31) days of your date of hire, then the University will provide full-time staff employees with either 5 vacation days or \$500 and will provide full-time faculty members with \$500. The University will pay you the \$500 or you will accrue the vacation days, as applicable, on a prorated basis in each paycheck throughout the Plan Year. If you make no election or waiver within thirty-one days of the date coverage was offered, you will not be enrolled in the Medical Plan and will not receive the 5 vacation days or \$500.

Pre-Tax Payments Under the Flex Plan

Under the Flex Plan, you may choose to redirect a portion of your compensation to pay for your share of the costs of benefits under the Component Programs (the Premium Conversion feature) and/or set aside money to pay for unreimbursed qualifying medical expenses (Medical FSA or HSA) and/or qualifying dependent care expenses (Dependent Care FSA), all with pre-tax dollars. This means that you will pay less in taxes each year.

To enroll, you must complete an enrollment form/salary reduction agreement, which may be electronic. However, even if you do not complete an enrollment form/salary reduction agreement, you will

automatically be enrolled in the Premium Conversion feature once you enroll in the Medical Plan or Dental Plan.

Election Changes During the Plan Year

You may change your elections with respect to the Medical Plan, Dental Plan, Voluntary Vision Plan, Voluntary Life Insurance Program, Medical FSA, Dependent Care FSA, Voluntary Injury Insurance, Voluntary Hospital Insurance, and Legal Resources during the Plan Year only as described below, each of which is called a “permitted election change event.” Your mid-year election change must be consistent with the permitted election change event and must be submitted within 31 days of the event. Please contact the Plan Administrator if you have a question about whether an event is a permitted election change event under the Premium Conversion feature.

You may change your election for your HSA at any time during the Plan Year.

Qualified Life Status Change Events

The election you make (or are deemed to have made) will apply to your coverage for the Plan Year beginning each January 1st. Generally, you cannot change your election during a Plan Year; however, you may change your elections during a Plan Year if you experience a “change in status” which includes events that, among other things:

- change your marital status (e.g., marriage, divorce, annulment);
- change the number of your children (e.g., birth, death, or adoption or placement of adoption of a child);
- change the employment status of you or your spouse or children (e.g., termination or commencement of employment, commencement of or return from extended unpaid leave of absence, change in worksite);
- cause your spouse or children to satisfy or cease to satisfy requirements for coverage on account of, among other things, attainment of a certain age; or
- change the place of residence for you or your spouse or children.

Cost Changes

If there is a significant increase or decrease in the cost of your coverage under one or more Component Programs, as determined by the Plan Administrator, you may be permitted to:

- make a corresponding change to your election;
- in the case of a significant decrease in cost, revoke your election and elect coverage under the less expensive option, or elect such less expensive option for the first time if you previously declined coverage; or
- in the case of a significant increase in cost, revoke your existing election and elect coverage under another option providing similar coverage (if no alternative similar coverage is available, you may revoke your election with respect to such coverage).

Any insignificant change in the cost of your coverage will result in an automatic increase or decrease, as applicable, in your share of the total cost.

Note that you may not change your election with respect to the Medical FSA during a Plan Year due to a cost change.

Coverage Changes

- Curtailement or Loss of Coverage. If your benefits coverage under one or more Component Program(s) is significantly curtailed or ceases entirely, you may revoke your elections for that program and elect coverage under another option providing similar coverage, if one is available. Coverage is significantly curtailed if there is an overall reduction in coverage generally. If the curtailment is equivalent to a complete loss of coverage, and no other similar coverage is available, you may revoke your existing election for coverage.
- Addition to or Improvement in Coverage. If the University adds or significantly improves a Component Program or Benefit Option during the year, and you had elected a program or option providing similar coverage, you may revoke your existing election and instead elect the newly added or newly improved program or option or elect the significantly improved option if you previously declined coverage.
- Changes in Coverage Under Another Employer Plan. If your Eligible Dependent's health plan allows for a change in his or her coverage (either during that employer's open enrollment period or due to a mid-year election change permitted under the Code), you may be able to make a corresponding election change. For example, if your spouse elects family medical coverage during his or her employer's open enrollment period, you may drop your Medical Plan coverage.

Note that you may not change your election with respect to the Medical FSA during a Plan Year due to a coverage change.

Entitlement to Governmental Benefits

If you or your Eligible Dependent becomes entitled to, or loses entitlement to, Medicare, Medicaid or certain other governmental group medical programs, you may make a corresponding change under the relevant Component Program(s).

Judgment, Decree, or Order (including QMCSOs)

If a judgment, decree or order (including a QMCSO) requires a Component Plan to provide coverage to your child, then the Plan Administrator automatically may change your election under the Component Plan to provide coverage for that child on a prospective basis. In addition, you may make corresponding election changes as a result of such judgment, decree or order, if you desire.

If the judgment, decree or order requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child if you provide proof to the Plan Administrator that such other person actually provides the coverage for the child.

Special Enrollment Rights

If you do not enroll yourself and your Eligible Dependents in any of the Component Programs that are group health plans, as identified in the Attachments, after you become eligible or during annual open enrollment, you may be able to enroll under the special enrollment rules under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) that apply when an individual initially declines coverage and later wishes to elect it.

Generally, special enrollment is available if (i) you initially declined coverage because you had other health care coverage that you have now lost through no fault of your own; or (ii) since declining coverage initially, you have acquired a new dependent (through marriage or the birth or adoption of a child) and wish to cover that person. When you have previously declined coverage, you must have given (in writing) the alternative coverage as your reason for waiving coverage under any of the Component Programs that are group health plans, as identified in the Attachments when you declined to participate. In either case, as long as you meet the necessary requirements, you can enroll both yourself and all Eligible Dependents in any of the Component Programs that are group health plans, as identified in the Attachments, within 31 days after you lose your alternative coverage or the date of your marriage or the birth, adoption, or placement for adoption of your child.

You may also enroll yourself and your Eligible Dependents in a Component Program that is a group health plan if you or your Eligible Dependents’ coverage under Medicaid or the state Children’s Health Insurance Program (SCHIP) is terminated as a result of loss of eligibility, or if you or one of your Eligible Dependents become eligible for premium assistance under a Medicaid or SCHIP plan. Under these two circumstances, the special enrollment period must be requested within 60-days of the loss of Medicaid or SCHIP coverage or of the determination of eligibility for premium assistance under Medicaid or SCHIP.

PARTICIPATION

Beginning of Benefits

If you are eligible for and enroll in benefits under the Plan, as explained in the prior sections, your benefits under the various Component Programs will begin as of the following dates:

	Medical Plan, Dental Plan, Voluntary Vision Plan	Life/AD&D Insurance, LTD Plan, EAP, STD Plan	Voluntary Life Insurance Program, Flex Plan, Legal Resources	Voluntary Injury Insurance and Voluntary Hospital Insurance
Newly hired employees	First day of the month following date of hire (or date of hire if hire occurs on first work day of a month)	First day of employment	Later of first day of employment or date the enrollment form is signed	Within 31 days of employment after the enrollment form is signed
Employees who switch from part-time to full-time	First day of the month following date of switch to full-time status (or date of switch if switch occurs on first work day of a month)	First day of the switch to full-time status	Later of first day of switch to full-time status or date the enrollment form is signed	Within 31 days of the change, after the enrollment form is signed

Loss of Benefits

The University reserves the right to change or eliminate any Component Program and amend or terminate the Plan. Except in the case of certain health care continuation rights under Federal law discussed below, all benefits (other than benefits under the EAP, the Pre-65 Retiree Medical Benefits Program, the Post-Retirement Medical Benefits Program or the Closed Retiree Medical Benefits Program) end in connection with termination of your active, full-time employment as set forth in the chart below (subject to the terms of any severance agreement, in which case, participation will terminate as set forth in such agreement) or when you are no longer eligible or when the group insurance policy terminates, whichever occurs first. Benefits under the EAP end 36 months after your termination date, or, if earlier with respect to your Eligible Dependents, 36 months after they cease to be your Eligible Dependents.

Benefit Termination as a result of Employment Status Change:

	Medical Plan, Dental Plan, Voluntary Vision Plan, Medical FSA, Legal Resources	Life/AD&D Insurance, LTD Plan, Voluntary Life Insurance Program, STD Plan, Dependent Care FSA, Voluntary Injury Insurance, Voluntary Hospital Insurance
Terminated employees	Last day of the month following termination date (or date of termination if termination occurs on last day of a month)	Last day of employment
Employees who switch from full-time to part-time	Last day of the month following date of switch to part-time status (or date of switch if switch occurs on last day of a month)	Last day of full-time employment

You should consult the applicable Attachments for specific information about termination and continuation of coverage in accordance with an insurance policy to which a required premium is paid.

DISCLOSURES AND NOTICES

Your Rights Under ERISA

As a participant in certain Component Programs, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA does not apply to the Dependent Care FSA, the HSA, or the STD Plan. ERISA provides that all participants in the ERISA-governed Component Programs are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain copies of all Plan documents and other Plan information including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description upon written request to the Plan Administrator. 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 summary plan description and the documents governing the Plan particularly the rules governing your COBRA continuation coverage rights; and
- A reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan participants. No one, including the University or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, 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 schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in 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 this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, including COBRA, HIPAA and other laws affecting the Plan or need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. You may also visit their website at www.dol.gov/ebsa.

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order ("QMCSO") is an order by a court for a parent to provide a child or children with health insurance under a group health plan. The Plan Administrator will comply with the terms of any QMCSO it receives, and will:

- Establish reasonable procedures to determine whether medical child support orders are qualified medical child support orders as defined under ERISA Section 609;
- Promptly notify you and any alternate recipient (as defined in ERISA Section 609(a)(2)(C)) of the receipt of any medical child support order, and the Plan's procedures for determining whether medical child support orders are qualified medical child support orders; and
- Within a reasonable period of time after receipt of such order, the Plan Administrator will determine whether such order is a qualified medical child support order and will notify you and each alternate recipient of such determination.

Special Rule for Maternity and Infant Coverage

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

Special Rule for Women’s Health Coverage

The Women’s Health and Cancer Rights Act of 1998 (“WHCRA”) requires group health plans, insurance issuers and HMOs that provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (iii) prostheses and physical complications at all stages of mastectomy, including lymphedemas. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other medical or surgical benefits provided under the Medical Plan. For answers to specific questions regarding WHCRA benefits, contact the Plan Administrator. Additional state laws may be applicable as more fully described in the Medical Plan documents attached as Attachments #1, 2, and 3.

Access to OB/GYN Care

You do not need prior authorization from the Plan or from any other person, including your PCP, in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. You or the provider, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit the Cigna.com [Uniformed Services Reemployment Rights](#)

Your right to continued participation in a Component Program that is a group health plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums in the manner specified by the University.

If you do not elect to continue to participate in a Component Program that is a group health plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage for the 18-month period that begins on the first day of your leave of absence. You must pay the premiums for continuation coverage with after-tax funds, subject to the rules that are set out in the Plan.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. See below for more information about your COBRA rights. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

Leaves under Family Medical Leave Act (“FMLA”)

If you take a leave of absence (i) for your own serious health condition, (ii) to care for family members with a serious health condition, (iii) to care for a newborn or adopted child, (iv) to care for an injured or ill covered service member of the Armed Forces or (v) due to a qualifying exigency arising out of a covered service member’s active duty, you may be able to continue your health coverage under the Plan. If you drop your health coverage during the leave, you can also have your health coverage reinstated on the date you return to work assuming you pay any contributions required for the coverage. Contact the Plan Administrator for more information about your FMLA rights.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

Plan Administrator

The Plan Administrator has (i) the power and authority in its sole, absolute and uncontrolled discretion to control and manage the operation and administration of the Plan and (ii) all powers necessary to accomplish these purposes.

The Plan Administrator will administer the Plan in accordance with established policies, interpretations, practices, and procedures and in accordance with the requirements of ERISA and other applicable laws. With respect to the Plan, the Plan Administrator has discretion (i) to interpret the terms of the Plan, (ii) to determine factual questions that arise in the course of administering the Plan, (iii) to adopt rules and regulations regarding the administration of the Plan, (iv) to determine the conditions under which benefits become payable under the Plan and (v) to make any other determinations that the Plan Administrator believes are necessary and advisable for the administration of the Plan. Subject to any applicable claims procedure, any determination made by the Plan Administrator will be final, conclusive and binding on all parties. The Plan Administrator may delegate all or any portion of its authority to any person or entity.

A claims administrator may, at the discretion of the Plan Administrator, have the sole and absolute discretionary authority to administer, apply, and interpret Plan provisions. All claims should be directed to the applicable administrator (either the claims administrator or the Plan Administrator) and the entire claims and appeals process, as described in this Plan document or in the Attachments, will be handled through that administrator.

Under the terms of any insurance contracts issued for the Component Programs, the insurance company issuing the contract has full discretionary authority to make all benefit decisions concerning eligibility for benefits under the contract, payment of claims or benefits, and interpretation of the terms and provisions of the insurance contract. Only the insurance company can resolve insurance contract ambiguities, correct errors or omissions in the contract, and interpret contract terms. The insurance company has the full discretionary authority to interpret, construe and administer the terms of such policies, and its decisions are final and binding on all parties. The Plan Administrator does not guarantee the payment of any benefit described in an insurance coverage contract and you must look solely to the insurance carrier for the payment of benefits.

Duties of the Plan Administrator

The Plan Administrator will (i) administer the Plan in accordance with its terms, (ii) decide disputes which may arise relative to a Plan participant's rights, (iii) keep and maintain the Plan documents and all other records pertaining to the Plan, (iv) pay or arrange for the payment of claims, (v) establish and communicate procedures to determine whether a medical child support order is qualified under Section 609 of ERISA, and (vi) perform all necessary reporting as required by ERISA.

Plan Administrator Compensation

While the Plan Administrator serves without compensation, all expenses for administration, including compensation for hired services, will be paid by the Plan unless paid by the University.

Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to eligible employees and their eligible dependents and defraying reasonable expenses of Plan administration. These duties must be carried out with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation and in accordance with Plan documents to the extent that they are consistent with ERISA.

The Named Fiduciary

The Plan Administrator is a “named fiduciary” with respect to the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. The Plan Administrator has delegated certain day-to-day administration of the Plan and claims fiduciary responsibility for the processing and review of claims for benefits under the Plan, including COBRA claims and administration, to certain third-party administrators and claim administrators listed in Schedule A. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary will not be liable for any act or omission of such person unless either (i) the named fiduciary has violated its duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures or (ii) the named fiduciary breached its fiduciary responsibility under ERISA Section 405(a).

COBRA

Introduction

The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Medical Plan, the Dental Plan, and/or the Medical FSA (the “COBRA-Eligible Component Programs”) when you would otherwise lose such group health plan coverage. **The following generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your COBRA rights and obligations under the COBRA-Eligible Component Programs and under Federal law, you should ask the Plan Administrator.

The Plan Administrator has delegated authority for administering COBRA continuation coverage to the following COBRA Administrator:

**Flores & Associates
P.O. Box 31397
Charlotte, NC 28231-1397
Telephone Number: (800) 532-3327**

COBRA Continuation Coverage

Eligibility

COBRA continuation coverage is a continuation of group health plan, dental and/or medical flexible spending account coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under a COBRA-Eligible Component Program because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage under a COBRA-Eligible Component Program must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under a COBRA-Eligible Component Program because either one of the following qualifying events happens:

- A reduction in your hours of employment; or
- Your employment ends for any reason other than your gross misconduct and you do not become covered under the Pre-65 Retiree Medical Benefits Program.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under a COBRA-Eligible Component Program because any of the following qualifying events happen:

- Your spouse dies;

- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct and your spouse does not become covered under the Pre-65 Retiree Medical Benefits Program;
- Your spouse becomes entitled to Medicare (Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under a COBRA-Eligible Component Program because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's regularly scheduled hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct and the parent-employee does not become covered under the Pre-65 Retiree Medical Benefits Program;
- The parent-employee becomes entitled to Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as an Eligible Dependent.

Notification by the University

The COBRA-Eligible Component Program will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or entitlement of the employee to Medicare (Part A, Part B, or both), the University must notify the COBRA Administrator of the qualifying event within 30 days of the date the event occurs or the date you would otherwise lose coverage under the group health plan due to a qualifying event, whichever is later.

Notification by the Employee

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The group health plan requires you to notify the Plan Administrator within 60-days after the qualifying event occurs or the date you would otherwise lose coverage under the COBRA-Eligible Component Program due to a qualifying event, whichever is later. You must send this notice to the Plan Administrator in accordance with the procedures set forth below under "Furnishing Notice to Plan Administrator or COBRA Administrator." The Plan Administrator will then notify the COBRA Administrator that you or your family member has experienced a qualifying event, and all further communication regarding your or your family member's COBRA continuation coverage will occur between you or your family member and the COBRA Administrator.

Election

Within 14 days of the COBRA Administrator or Plan Administrator, as applicable, receiving notice that a qualifying event has occurred, the COBRA Administrator will send out an election notice, offering COBRA continuation coverage to each of the qualified beneficiaries.

For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that group health plan coverage would otherwise have been lost.

Period of Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as an Eligible Dependent, COBRA continuation coverage lasts for up to 36 months.

The maximum COBRA continuation coverage period is 24 months for employees on military leave who are covered by USERRA.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or any of your Eligible Dependents covered under a COBRA-Eligible Component Program is determined by the Social Security Administration to be disabled at any time during the first 60-days of COBRA continuation coverage and you notify the COBRA Administrator in a timely fashion, you and your Eligible Dependents can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the COBRA Administrator is notified of the Social Security Administration's determination within 60-days of the latest of the date of the determination, the date of the qualifying event or the date you would otherwise lose coverage under the COBRA-Eligible Component Program due to a qualifying event, and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures set forth below under "Furnishing Notice to COBRA Administrator."

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

If your Eligible Dependents experience another qualifying event while receiving COBRA continuation coverage, and such event would result in loss of coverage under a COBRA-Eligible Component Program if the first qualifying event had not already occurred, your Eligible Dependents can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to your Eligible Dependents if you die, become entitled to Medicare (Part A, Part B, or both), or get divorced or legally separated. The extension is also available to a child when that child stops being eligible under the COBRA-Eligible Component Program. In all of these cases, you must make sure that the COBRA Administrator is notified of the second qualifying event within 60-days of the second qualifying event or the date you would otherwise lose coverage under a COBRA-Eligible Component Program due to a qualifying event, whichever is later. This notice must be sent to the COBRA Administrator in accordance with the procedures set forth below under "Furnishing Notice to Plan Administrator or COBRA Administrator."

Furnishing Notice to Plan Administrator or COBRA Administrator

You should follow these procedures when notifying the Plan Administrator or COBRA Administrator of a Qualifying Event or a disability determination. Failure to follow these procedures may cause loss of coverage.

When furnishing a notice to the Plan Administrator (or his or her delegate) with respect to the occurrence of a qualifying event, such notice must be delivered to the Plan Administrator (or his or her delegate) (i) by hand-delivery, (ii) via facsimile, followed by written confirmation by first class mail; (iii) e-mail at achan@richmond.edu; or (iv) by registered or certified mail, return receipt requested. Such notice must include the name(s) of the covered employee and/or qualified beneficiaries, as applicable, a general description of, and circumstances surrounding, the qualifying event, and the date of such qualifying event. Once the Plan Administrator (or his or her delegate) receives such notice, it reserves the right to make further inquiry to verify the circumstances surrounding such qualifying event, and to delegate to the COBRA Administrator the ability to make this inquiry.

After you are receiving COBRA continuation coverage, if you experience a second qualifying event or become disabled, you must notify the COBRA Administrator. When furnishing a notice to the COBRA Administrator with respect to the occurrence of a second qualifying event or with respect to a disability determination by the Social Security Administration, such notices must be delivered to the COBRA Administrator (i) by hand-delivery, (ii) via facsimile, followed by written confirmation by first class mail; online at www.flores247.com; or (iv) by registered or certified mail, return receipt requested. Such notices must include the name(s) of the covered employee and/or qualified beneficiaries, as applicable, a general description of, and circumstances surrounding, the qualifying event or disability determination, and the date of such qualifying event or disability determination. Once the COBRA Administrator receives such notice, it reserves the right to make further inquiry to verify the circumstances surrounding such second qualifying event or disability determination.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep the Plan Informed of Address Changes

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

HIPAA PRIVACY PROVISIONS

Disclosure of Information

The University may only use and/or disclose Protected Health Information (as such term is defined in 45 C.F.R. §164.501) as permitted by the “Standards for Privacy of Individually Identifiable Health Information” under the Health Insurance Portability and Accountability Act of 1996 and applicable guidance (the “Rule”).

The Component Programs that are “group health plans” (as defined by the Rule) will disclose Protected Health Information to the University only upon its receipt of a certification by the University that the Component Program has been amended to incorporate the following provisions and that the University agrees to:

- Not use or further disclose the information other than as permitted or required by the Component Program documents or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides Protected Health Information received from the Component Program agree to the same restrictions and conditions that apply to the University with respect to such information;
- Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the University;
- Report to the Component Program any use or disclosure of the Protected Health Information that is inconsistent with the uses or disclosures permitted by the Rule of which it becomes aware;
- Make available Protected Health Information based on HIPAA’s access requirements in accordance with 45 C.F.R. §164.524;
- Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. §164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528;
- Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Component Program available to the Secretary of Health and Human Services for purposes of determining compliance by the Component Program with the Rule;
- If feasible, return or destroy all Protected Health Information received from the Component Program that the University still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

- Ensure that adequate separation of the Component Program and the University is established as required by 45 C.F.R. §164.504(f)(2)(iii) as described below.

There are some special rules under HIPAA related to “electronic protected health information.” Electronic health information is generally protected health information that is transmitted by, or maintained in, electronic media. “Electronic media” includes electronic storage media, including memory devices in a computer (such as hard drives) and removable or transportable digital media (such as magnetic tapes or disks, optical disks and digital memory cards). It also includes transmission media used to exchange information already in electronic storage media, such as internet, an extranet (which uses internet technology to link a business with information accessible only to some parties), leased lines, dial-up lines, private networks and the physical movement of removable/transportable electronic storage media.

Please be advised that, as required by HIPAA, Component Programs that are “group health plans” (as defined by the Rule) will take additional action with respect to the implementation of security measures (as defined in 45 C.R.F. §164.304) for electronic protected health information. Specifically, the Component Program will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Component Program;
- Ensure that the adequate separation required to exist between the Plan and the University is supported by reasonable and appropriate administrative, physical and technical safeguards in its information systems;
- Ensure that any agent, including a subcontractor, to whom it provides electronic protected health information, agrees to implement reasonable and appropriate security measures to protect that information;
- Report to the Component Program if it becomes aware of any attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in its information systems; and
- Comply with any other requirements that the Secretary of the U.S. Department of Health and Human Services may require from time to time with respect to electronic protected health information by the issuance of additional regulations or other guidance pursuant to HIPAA.

Certification of the University

A Component Program (or a health insurance issuer with respect to a Component Program if applicable) will disclose Protected Health Information to the University only upon the receipt of a certification by the University that the Component Program incorporates the provisions of 45 CFR §164.504(f)(2)(ii), and that the University agrees to the conditions of disclosure set forth above. The Component Program will not disclose and may not permit a health insurance issuer to disclose Protected Health Information to the University as otherwise permitted herein unless the statement required by 45 CFR §164.520(b)(1)(iii)(C) is included in the appropriate notice.

Separation of Plan and the University

The following employees (or classes of employees) or other persons under the control of the University will be treated as the workforce of the University and are permitted to have access to Protected Health Information disclosed by the Component Program (“Permitted Employees”):

- Human Resources
- HIPAA Privacy/Security Compliance Officer and his or her delegates
- Legal Department

Despite the foregoing, any employee or person not described above who receives Protected Health Information relating to payments under, health care operations of, or other matters pertaining to the Component Program in the ordinary course of business, will also be included in the definition above of Permitted Employees.

The Permitted Employees may only use the Protected Health Information for administrative functions of the Component Program that the University performs for the Component Program.

HIPAA Notice of Privacy Practices

The University or the group health issuers maintain a HIPAA Notice of Privacy Practices that provides information to individuals whose protected health information will be used or maintained by the Component Programs that are “group health plans” (as defined by the Rule). If you would like a copy of the HIPAA Notice of Privacy Practices, please see the Plan Administrator.

CLAIMS PROCEDURES

Group Health Plan Claim Processing

Your claims under the Plan's group health plan Component Programs will be processed under the following procedures, except to the extent inconsistent with the insurer's or claim administrator's claims procedures as set forth in an Attachment, *in which case the insurer's or claims administrator's claims procedures will apply as long as such other claims procedures comply with the Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act") and guidance issued thereunder and DOL Regulation § 2560.503-1*. For more detailed information, you should review the applicable Attachment, or you may contact the claims administrators directly to obtain specific claim/appeal processes. Additional information regarding these enhancements that are not described below will be provided in a future Summary of Material and in any written claim denial notice you receive.

Internal Review

Initial Claim Processing

Post-Service Claims

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

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

Pre-Service Claims

Pre-Service Claims are those claims that require notification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the claims administrator within 15 days of receipt of the claim. If you filed a pre-service claim improperly, the claims administrator will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. The claims administrator will notify you within this 15-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and hold your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the claims administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

Urgent Claims that Require Immediate Action

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition, could cause severe pain. In these situations, you will receive notice of the benefit determination as soon as possible, but no later than 72 hours unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered under the Component Program. Notice of denial may be provided orally with a written or electronic confirmation to follow within 3 days.

If you filed an Urgent Care Claim improperly, the claims administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the claims administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

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

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

Concurrent Care Claims

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

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

Notification of Claim Denial

If the claims administrator denies any part or all of a benefit claim, it will provide you with a written notice (although initial notice of a denied urgent care claim may be provided to you orally). The written notice will include the specific reason or reasons for the denial and a reference to the Plan provisions on which the denial is based. This notice will be provided in a culturally and linguistically appropriate manner, as determined under regulations implementing the Affordable Care Act, and will include the following:

- Identifying Claim Information – information identifying the claim involved, including the date of service, the health care provider, and the claim amount. The diagnosis code, the treatment code

and the corresponding meaning of these codes are available upon request from the Plan Administrator, and will be provided as soon as practicable following your request;

- Reason for the Denial – the specific reason or reasons for the denial, the denial code(s), and the corresponding meaning of the code(s);
- Standard for the Denial – a description of the specific standard, if any, used in denying the claim;
- 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;
- Description of Scientific or Clinical Judgment – if the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided to you free of charge upon your request;
- Description of Claims Appeals Procedures – a description of the Plan’s internal appeals procedures and external review process, including information on how to initiate an appeal, 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); and
- Contact Information – the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist you with the internal claims and appeals and external review processes.

Coordination of Benefits

If you or your Eligible Dependent has or is entitled to benefits under another health plan, you are subject to a coordination of benefits process. Coordination of benefits is designed to prevent the payment of benefits from exceeding 100% of any allowable expenses that have been incurred. The Plan Administrator may request an Explanation of Benefits (EOB), which provides detailed claim reimbursement information from any other plans under which you are covered. If any of these plans provide coverage for services that are also covered under the Plan, the carrier will determine which plan is considered primary before any payments are made. The Attachments provide more detailed information on how your benefits under this Plan will be coordinated with other coverage you may have.

Appealing the Denial of a Claim

If your claim is denied, you may appeal that decision. To appeal, you must submit a written request to the claims administrator within 180 days of receiving the initial claim denial. Along with the written request for appeal, you may submit any additional facts, documents or proof you believe will show why the claim should not be denied. If the written request for appeal is not submitted within 180 days of receiving the initial claim denial, you lose the right to appeal under the Plan.

Pre-Service and Post-Service Claim Appeals

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

For appeals of Pre-Service Claims (as defined above), you will be notified by the claims administrator of the decision within 30 days from receipt of a request for appeal of a denied claim.

For appeals of Post-Service Claims (as defined above) and of denials of claims based on medically necessary treatments or experimental or investigational services (as defined in the applicable Attachments), the appeal will be conducted by the claims administrator and you will be notified by the claims administrator of the decision within 60 days from receipt of a request for appeal of a denied claim.

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

Urgent Claim Appeals That Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your doctor should call the claims administrator as soon as possible, and provide the claims administrator with the information identified above under "How to Appeal a Claim Decision." The claims administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

Notification of Claim Denial on Appeal

If the claims administrator denies any part of your appeal, it will provide you with a written notice. The written notice will include the specific reason or reasons for the denial and a reference to the Plan provisions on which the denial is based. This notice will be provided in a culturally and linguistically appropriate manner, as determined under regulations implementing the Affordable Care Act, and will include the following:

- Identifying Claim Information – information identifying the claim involved, including the date of service, the health care provider, and the claim amount. The diagnosis code, the treatment code and the corresponding meaning of these codes are available upon request from the Plan Administrator, and will be provided as soon as practicable following your request;

- Reason for the Denial – the specific reason or reasons for the denial, the denial code(s), and the corresponding meaning of the code(s);
- Standard for the Denial – a description of the specific standard, if any, used in denying the claim;
- Reference to Plan Provisions – reference to the specific Plan provisions on which the denial is based;
- 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;
- Description of Scientific or Clinical Judgment – if the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided to you free of charge upon your request;
- Statement of Right to Initiate External Review Process or Bring Action – a statement that you are entitled to initiate external review of your claim or bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits; and
- Contact Information – the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist you with the internal claims and appeals and external review processes.

The decision of the claims administrator will be final and conclusive, and binding on all persons claiming benefits under the Plan, subject to applicable law. If you challenge the decision of the claims administrator, the external review or review by a court of law will be limited to the facts, evidence and issues presented during the internal claims procedure set forth above. The internal appeal process described herein must be exhausted before you can initiate an external review as described below or pursue the claim in Federal court, unless: (i) the Plan failed to follow the internal claims procedures described above and the Plan's failure is more than *de minimis* and is likely to cause prejudice or harm to you; or (ii) with respect to the external review, requiring you to exhaust the internal claims and appeals procedure would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, in which cases you will be deemed to have exhausted such process. 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.

Voluntary External Review

If you exhaust the internal group health plan claim and appeal procedures (or earlier, if you are deemed to have exhausted such procedure due to the Plan's failure to comply with the procedure), you will have the right to request an external (i.e., independent) review with respect to any claim other than a claim related to employee classifications if you do so within four months after receiving notice of an adverse benefit determination or final internal adverse benefit determination.

Within five business days after receiving your request, a preliminary review will be completed to determine whether: (i) you are/were covered under the Plan; (ii) the denial was based on your ineligibility under the terms of the Plan; (iii) you exhausted the Plan's internal claims and appeals process, if required; and (iv) you provided all information necessary to process the external review. Within one business day after completing the preliminary review, you will be notified in writing if your request is not eligible for an external review or if it is incomplete. If your request is complete but not eligible, the notice will include the reason(s) for ineligibility. If your request is not complete, the notice will describe any information needed to complete the request. You will have the remainder of the four-month filing period or 48 hours after receiving the notice, whichever is greater, to cure any defect. If eligible for an external review, your request will be assigned to an independent review organization (IRO). The IRO will provide written notice of its final external review decision within 45 days after the IRO receives the request for external review. If the IRO reverses the adverse benefit determination or final internal adverse benefit determination, then the Plan will cover the claim.

In addition, you will have the right to an expedited external review in the following situations:

- Following an adverse benefit determination involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the covered person or would jeopardize his or her ability to regain maximum function and you have filed a request for an expedited internal appeal.
- Following a final internal adverse benefit determination involving (i) a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the covered person's life or health or would jeopardize his or her ability to regain maximum function or (ii) an admission, availability of care, continued stay, or health care item or service for which the covered person received emergency services but has not been discharged from a facility.
- The IRO will provide notice of its final external review decision as expeditiously as the claimant's medical condition or circumstances require, but not more than 72 hours after the IRO receives the request.

Life and AD&D Claim Processing

Your Life and AD&D Plan claims will be processed under the following claims procedures, except to the extent inconsistent with the insurers' claims procedures, in which case the insurers' claims procedures will apply. For more detailed information, please review the applicable Attachment, or you may contact the claims administrator directly to obtain specific claims/appeal processes.

Initial Claim Processing

The claims administrator will process your initial claim within 90 days of receipt unless your claim filing is incomplete. The claims administrator may extend this period one time for up to 90 days if the extension is necessary due to matters beyond its control. If an extension is necessary, the claims administrator will notify you before the end of the initial 90-day period and tell you when it expects to make a decision.

If your claim is incomplete, the claims administrator will notify you or your representative of the incomplete claim within the initial 90-day period and specify the information needed to complete

processing of your claim. You will be given 45 days to respond to the request for additional information and the claims administrator will process your completed claim within 90 days of receipt. If you don't provide the necessary information, your claim will be denied.

If the claims administrator denies any part or all of a benefit claim, it will provide you with a written notice, which will include the following:

- Identifying Claim Information – information identifying the claim involved;
- 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 Claims Appeals Procedures – a description of the Plan's internal appeals procedures and external review process, including information on how to initiate an appeal, 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
- Contact Information – the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist you with the internal claims and appeals and external review processes.

Appealing the Denial of a Claim

If your claim is denied, you may appeal that decision. To appeal, you must submit a written request to the claims administrator within 60 days of receiving the initial claim denial. Along with the written request for appeal, you may submit any additional facts, documents or proof you believe will show why the claim should not be denied. If the written request for appeal is not submitted within 60 days of receiving the initial claim denial, you lose the right to appeal under the Plan.

The claims administrator will process your written request for appeal within 60 days of receipt. If the claims administrator denies all or part of your appeal, it will provide you with a written notice, which will include the following:

- Identifying Claim Information – information identifying the claim involved;
- 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 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; and
- Contact Information – the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist you with the internal claims and appeals and external review processes.

Long Term Disability Claim Processing

Your LTD claims will be processed under the following claims procedures, except to the extent inconsistent with the claims administrator's claims procedures, in which case the claims administrator's claims procedures will apply. For more detailed information, please review the applicable Attachment, or you may contact the claims administrator directly to obtain specific claims/appeal processes.

Initial Claim Processing

The claims administrator will process your initial claim for LTD benefits within 45 days of receipt unless your claim filing is incomplete. The claims administrator may extend this period for 30 days if the extension is necessary due to matters beyond its control. If an extension is necessary, the claims administrator will notify you before the end of the initial 45-day period and tell you when it expects to make a decision. If prior to the end of the 30-day extension, the claims administrator determines that due to reasons beyond its control a decision cannot be given within the extension period, the decision period can be extended another 30 days.

If your claim is incomplete, the claims administrator will notify you or your representative of the incomplete claim within the initial 45-day period and specify the information needed to complete processing of your claim. You will be given 45 days to respond to the request for additional information and the claims administrator will process your completed claim within 45 days of receipt. If you do not provide the necessary information, your claim will be denied.

If the claims administrator denies any part or all of a benefit claim, it will provide you with a written notice, which will include the following:

- Identifying Claim Information – information identifying the claim involved;
- 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 Claims Appeals Procedures – a description of the Plan's internal appeals procedures and external review process, including information on how to initiate an appeal, 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

- Contact Information – the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist you with the internal claims and appeals and external review processes.

Appealing the Denial of a Claim

If your claim is denied, you may appeal that decision. To appeal, you must submit a written request to the claims administrator within 180 days of receiving the initial claim denial. Along with the written request for appeal, you may submit any additional facts, documents or proof you believe will show why the claim should not be denied. If the written request for appeal is not submitted within 180 days of receiving the initial claim denial, you lose the right to appeal under the Plan.

The claims administrator will process your written request for appeal within 45 days of receipt. If necessary, the claims administrator may extend the original 45-day period to process the claim. You will be notified in writing of the extension before the end of the first 45-day period. The total period for the appeal may not exceed 90 days.

If the claims administrator denies all or part of your appeal, it will provide you with a written notice, which will include the following:

- Identifying Claim Information – information identifying the claim involved;
- 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 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;
- Description of Scientific or Clinical Judgment – if the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided to you free of charge upon your request;
- 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; and
- Contact Information – the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist you with the internal claims and appeals and external review processes.

Non-Insurance Claim Processing

If a non-insurance related claim under a Component Program (i.e., the Dependent Care FSA or the STD Plan) is denied in whole or in part, you or your beneficiary will receive written or electronic notification. The notification will include the reason for the denial. Please contact the claims administrator for the applicable non-insurance Component Program for information regarding the availability, if any, for appeals of any denied non-insurance related claim. Note that the Dependent Care FSA and the STD Plan are not employee benefit plans under ERISA and the benefits under the Dependent Care FSA and the STD Plan are not subject to ERISA's claim and appeal processes.

Limited Time Period for Filing a Lawsuit

Notwithstanding any applicable statutory statute of limitations, no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review decision by the claims administrator has been rendered (or deemed rendered).

MISCELLANEOUS PROVISIONS

Amendment and Termination

The University reserves the right to amend any one or more of the underlying Plan features or Component Programs at any time and, to the extent permitted by law, without the consent of or prior notice to any employee or participant. Although the University expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan, any Component Program, or any feature thereof at any time without liability. Upon the termination of the Plan, any Component Program, or feature, as the case may be, all elections and reductions in compensation relating to the Plan, Component Program, or feature will terminate, and the rights of a participant covered under the Plan are limited to the payment of eligible expenses incurred prior to termination.

Right of Recovery; Termination of Coverage for Cause Including Fraud or Intentional Misrepresentation

There are times that you will be required to furnish information or proof necessary to determine your or an Eligible Dependent's right to a Plan benefit. When inaccurate information and/or proof is provided, this ultimately can result in the improper use of Plan assets, which adversely affects the ability of the Plan to provide the highest possible level of benefits.

Accordingly, the University reserves the right to terminate, prospectively without notice for cause, your and/or your Eligible Dependents' coverage under the Plan, if, as determined by the Plan Administrator, you and/or your Eligible Dependents are ineligible for coverage under the Plan. In addition, if you or an Eligible Dependent commits fraud, or intentional misrepresentation with respect to enrolling in the Plan's group health plan Component Programs, in a claim or appeal for benefits under such Component Programs, or in response to any request for information in connection with such Component Programs by the Plan Administrator or its delegates (including a claims administrator), the Plan Administrator may terminate your coverage under such Component Program retroactively upon 30 days' notice. Failure to inform such persons that you or your Eligible Dependent is covered under another group health plan or knowingly providing false information to obtain coverage for an ineligible dependent are examples of actions that constitute fraud under the Plan's group health plan Component Programs. Of course, if the Plan pays benefits actually incurred or in excess of allowable amounts, due to error (including for example, a clerical error) or for any other reason (including, for example, your failure to notify the Plan Administrator or its delegates regarding a change in family status), the Plan Administrator reserves the right to recover such overpayment through whatever means are necessary, including, without limitation, deduction of the excess amounts from future claims and/or legal action.

Subrogation and Reimbursement

Immediately upon paying or providing any benefit under the Plan's group health plan Component Programs, such Component Programs shall be subrogated to all rights of recovery a covered person has against any party potentially responsible for making any payment to a covered person due to a covered person's injuries or illness, to the full extent of benefits provided or to be provided by the Component Programs. In addition, if a covered person receives any payment from any potentially responsible party as a result of an injury or illness, the Component Programs have the right to recover from, and be reimbursed by, the covered person for all amounts such Component Programs have paid and will pay as

a result of that injury or illness, up to and including the full amount the covered person receives from all potentially responsible parties. Covered person includes, for the purposes of this provision, anyone on whose behalf the Component Programs pay or provide any benefit, including but not limited to the minor child or dependent of any participant or person entitled to receive any benefits from the Component Programs. The Plan's rights of subrogation and reimbursement set forth in this section supplement any statement of subrogation and/or reimbursement rights provided in any of the Attachments.

As used throughout this provision, the term responsible party means any party possibly responsible for making any payment to a covered person due to a covered person's injuries or illness or any insurance coverage, including but not limited to uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, med-pay coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The covered person shall do nothing to prejudice the applicable Component Program's subrogation and reimbursement rights and shall, when requested, fully cooperate with the Component Program's efforts to recover its benefits paid. It is the duty of the covered person to notify the Plan Administrator within 30 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages due to injuries sustained by the covered person. Any and all such funds recovered by the covered person shall remain traceable from the responsible party to the covered person and in the hands of the covered person. A covered person shall not dissipate any such funds received before reimbursing the Plan.

The covered person acknowledges that the applicable Component Program's subrogation and reimbursement rights are a first priority claim against all potentially responsible parties and are to be paid to such Component Program before any other claim for the covered person's damages. The applicable Component Programs shall be entitled to full reimbursement first from any potentially responsible party payments, even if such payment to the Component Program will result in a recovery to the covered person which is insufficient to make the covered person whole or to compensate the covered person in part or in whole for the damages sustained. The Component Program will pay an equitable portion of the attorneys' fees associated with recovering the covered person's damage claim.

The terms of this entire subrogation and reimbursement provision shall apply, and the applicable Component Program is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the covered person identifies the specific benefits the Component Program provided. The Component Program is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering or non-economic damages only.

If any claim is made that any part of this subrogation and reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan Administrator has the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Plan is Not an Employment Contract

The Plan will not be construed as a contract for or of employment.

MEDICAL PLAN OPTION ELIGIBILITY APPENDIX

Eligibility for the Medical Plan under the University of Richmond Employee Welfare Benefits Plan is determined in accordance with the look-back measurement method allowed by the Affordable Care Act. The following paragraphs describe the requirements for Medical Plan eligibility. For purposes of this Section, the term “Medical Benefits” means the “Medical Benefits for Active Employees” identified in the Plan’s Schedules. The Plan is intended to comply with and shall be interpreted and administered in a manner consistent with the applicable provisions of the Affordable Care Act and Treasury Regulation section 54.4980H-3.

(a) **Definitions.** The following definitions apply for purposes of this Section:

- (1) **Hour of Service** means each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer, and each hour for which an employee is paid, or entitled to payment by the Employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence (as defined in 29 CFR section 2530.200b-2(a)). The term “Hour of Service” does not include (i) any hour for services performed as a bona fide volunteer; (ii) any hour for services to the extent those services are performed as part of a Federal Work Study Program as defined under 34 CFR 675 or a substantially similar program of a state or a political subdivision thereof; or (iii) any hour for services to the extent compensation for those services constitutes income from sources without the United States (within the meaning of Code sections 861 through 863 and the regulations thereunder). Hours of Service performed by Employees classified by the University as “faculty” and other non-hourly employees (other than part-time exempt Employees and Employees classified by the University as salaried staff Employees) shall be calculated by using a daily equivalency whereby the Employee is credited with 10 Hours of Service for each day he or she works at least one Hour of Service, provided that an Employee will not be credited with fewer Hours of Service than he or she actually performed. An Employee shall be credited with an Hour of Service for each hour for which the Employee is required to remain on call on the University’s premises, or for which the Employee’s activities while remaining on call are subject to substantial restrictions that prevent the Employee from using the time effectively for the Employee’s own purposes.
- (2) **Employee** means a common law employee of the University of Richmond.
- (3) **Initial Measurement Period** means the twelve (12) month period that begins on the first day of the calendar month following a New Employee’s date of hire.
- (4) **Minimum Hours of Service** means thirty (30) Hours of Service.
- (5) **New Employee** means (A) an Employee who has been employed by the University for less than one complete Standard Measurement Period; or (B) an Employee who

terminated and resumed employment with the University and was not credited with an Hour of Service during a period of at least twenty-six (26) consecutive weeks.

- (6) **Ongoing Employee** means an Employee who has been employed by the University for at least one complete Standard Measurement Period.
- (7) **Part-Time Employee** means a New Employee who the University reasonably expects to be employed on average less than the Minimum Hours of Service per week during the Employee's Initial Measurement Period.
- (8) **Seasonal/Temporary Employee** means a New Employee who is hired into a position for which the customary annual employment is six (6) months or less.
- (9) **Stability Period** means, for an Ongoing Employee, the Plan Year. For a New Employee described in (b)(3), below, Stability Period means a twelve (12) month period commencing as of the first day of the calendar month beginning on or immediately after the first anniversary of the New Employee's first day of employment with the University.
- (10) **Standard Measurement Period** means the twelve (12) month period from October 3 of the prior calendar year to October 2 of the current calendar year.
- (11) **Variable Hour Employee** means a New Employee if, based on the facts and circumstances at the Employee's start date, the University cannot determine whether the New Employee is reasonably expected to be employed on average at least the Minimum Hours of Service per week during the Initial Measurement Period because the New Employee's hours are variable or uncertain. Factors to be considered when determining whether a New Employee is a Variable Hour Employee include, but are not limited to, the following:
 - (A) Whether the Employee is replacing an Employee who was a Regular Employee or a Variable Hour Employee;
 - (B) The extent to which the Hours of Service of Employees in the same or comparable positions have actually varied above and below an average of the Minimum Hours of Service per week during recent measurement periods; and
 - (C) Whether the position was advertised, or otherwise communicated to the Employee or otherwise documented as requiring Hours of Service that would average at least the Minimum Hours of Service per week.

(b) **Eligible Employees.** An Employee is eligible for Medical Benefits under the Plan, consistent with Affordable Care Act, if such Employee is classified by the University as "full-time regular faculty or staff" and/or satisfies one of the following:

- (1) **Regular Employees.** An Ongoing Employee who (i) is scheduled to work at least 1,511 Hours of Service per year; (ii) is a faculty member enrolled in the Faculty Phased Retirement Program; or (iii) was employed, on average, at least the Minimum Hours of

Service per week during the most recent Standard Measurement Period that ended before the Plan Year;

- (2) **New Regular Employees.** A New Employee who is hired to work (i) as “full-time regular faculty or staff”; (ii) at least 1,511 Hours of Service per year; or (iii) on average, at least the Minimum Hours of Service per week; or
- (3) **Other Employees.** A New Employee who is a Part-Time Employee, Seasonal/Temporary Employee or Variable Hour Employee who worked, on average, at least the Minimum Hours of Service per week during the Employee’s Initial Measurement Period.
- (4) **Mid-Year Change in Status.** If an Employee experiences a change in employment status such that, if the Employee had begun employment in the new position or status he or she would have been eligible for the Medical Plan, the Employee shall be an Eligible Employee as of the first day of the first full calendar month following the change in employment status.

(c) **Duration of Eligible Status.** Subject to the Plan’s termination of participation provisions, an Employee shall be treated as an Eligible Employee for Medical Benefits coverage as follows:

- (1) **Regular Employees.** An Ongoing Employee described in section (b)(1) shall be an Eligible Employee for Medical Benefits coverage for the entire Plan Year immediately following a Standard Measurement Period in which the Ongoing Employee was employed, on average, at least the Minimum Hours of Service per week, provided that the Ongoing Employee remains employed by the University. An Employee who ceases to be “full-time regular faculty or staff” shall cease to be an Eligible Employee for Medical Benefits unless such Employee is an Ongoing Employee who was employed, on average, at least the Minimum Hours of Service per week during the Standard Measurement Period preceding the Plan Year in which the Employee ceases to be “full-time regular faculty or staff” and the Employee remains employed by the University.
- (2) **New Regular Employees.** A New Employee described in section (b)(2) shall become an Eligible Employee for Medical Benefits coverage as of the first day of the month following or coincident with the New Employee’s date of hire. Such New Employee shall remain an Eligible Employee for Medical Benefits coverage through the end of the Plan Year in which the New Employee was hired by the Employer.
- (3) **Other Employees.** A New Employee described in section (b)(3) shall become an Eligible Employee for Medical Benefits coverage as of the first day of the first calendar month following or coincident with the anniversary of the New Employee’s date of hire. The New Employee shall remain eligible for Medical Benefits coverage for at least the duration of the New Employee’s Stability Period following such New Employee’s Initial Measurement Period. Additionally, if there is a period between the end of such Stability Period and the beginning of a Plan Year following the first full Standard Measurement Period during which the New Employee is employed by the Employer, the New Employee shall remain an Eligible Employee for Medical Benefits coverage until the beginning of such Plan Year.

(4) **Mid-Year Change in Status.** A New Employee described in section (b)(4) shall become an Eligible Employee as of the first day of the calendar month following or coincident with the New Employee's change in employment status. Such New Employee shall remain an Eligible Employee for Medical Benefits coverage through the last day of the Plan Year in which the New Employee became an Employee of the Employer.

(d) **Special Unpaid Leave and Employment Break Periods.**

(1) **Special Unpaid Leave.** An Employee's average Hours of Service for a measurement period shall be determined by crediting the Employee with Hours of Service for any periods of Special Unpaid Leave during that measurement period at a rate equal to the average weekly rate at which the Employee was credited with Hours of Service during the weeks in the measurement period that are not part of a period of Special Unpaid Leave. For purposes of this subsection, the term "Special Unpaid Leave" means:

- (A) Unpaid leave that is subject to the Family and Medical Leave Act of 1993;
- (B) Unpaid leave that is subject to the Uniformed Services Employment and Reemployment Rights Act of 1994; or
- (C) Unpaid leave on account of jury duty.

(2) **Employment Break Periods.** An Employee who is not a New Employee shall have his or her Hours of Service for a measurement period shall be determined by computing the average after excluding any employment break period of up to 501 Hours of Service during that measurement period and by using that average as the average for the entire measurement period. The number of Hours of Service excluded shall be determined by multiplying the average weekly rate for the measurement period (other than weeks in the measurement period that are part of a period of special unpaid Leave of an employment break period) by the number of weeks in the employment break period.

(e) **Rehired Employees.** An Employee who is eligible for Medical Benefits coverage and terminates and resumes employment during the Employee's Stability Period shall be eligible for Medical Benefits coverage as of the first day of the calendar month following the date he or she resumes employment with the Employer, provided the Employee is not a New Employee. If the Employee is a New Employee upon rehire, he or she must satisfy the eligibility requirements in section (b), above, to be eligible for the Medical Plan.

SCHEDULE A

University of Richmond Employee Welfare Benefits Plan Component Programs Available as of January 1, 2020

Medical Benefits for Active Employees and Eligible Pre-65 Retirees [See Attachment #1]	
Component Program:	Cigna Traditional Plan
Health Care Reform Status:	This Component Program is not a grandfathered group health plan for purposes of health care reform.
Insured by:	This Component Program is self-funded by the University.
Medical, Prescription Drug, and Mental Health and Substance Use Disorder Claims Administered by:	Cigna Healthcare P.O. Box 182223 Chattanooga, TN 37422-7223
Vision Claims Administered by:	Cigna Vision Claims Department P.O. Box 385018 Birmingham, AL 35238-5018
COBRA Administered by:	Flores & Associates P.O. Box 31397 Charlotte, NC 28231-1397 Telephone Number: (800) 532-3327
Administration Other than Claims and COBRA:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be shared by the University and the employees.

Medical Benefits for Active Employees and Eligible Pre-65 Retirees
[See Attachment #2]

Component Program:	Cigna High \$1,750 Deductible Health Plan
Health Care Reform Status:	This Component Program is not a grandfathered group health plan for purposes of health care reform.
Insured by:	This Component Program is self-funded by the University.
Medical and Prescription Drug Claims Administered by:	Cigna Healthcare P.O. Box 182223 Chattanooga, TN 37422-7223
Vision Claims Administered by:	Cigna Vision Claims Department P.O. Box 385018 Birmingham, AL 35238-5018
COBRA Administered by:	Flores & Associates P.O. Box 31397 Charlotte, NC 28231-1397 Telephone Number: (800) 532-3327
Administration Other than Claims and COBRA:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be shared by the University and the employees.

Medical Benefits for Active Employees and Eligible Pre-65 Retirees
[See Attachment #3]

Component Program:	Cigna High \$4,000 Deductible Health Plan
Health Care Reform Status:	This Component Program is not a grandfathered group health plan for purposes of health care reform.
Insured by:	This Component Program is self-funded by the University.
Medical and Prescription Drug Claims Administered by:	Cigna Healthcare P.O. Box 182223 Chattanooga, TN 37422-7223
Vision Claims Administered by:	Cigna Vision Claims Department P.O. Box 385018 Birmingham, AL 35238-5018
COBRA Administered by:	Flores & Associates P.O. Box 31397 Charlotte, NC 28231-1397 Telephone Number: (800) 532-3327
Administration Other than Claims and COBRA:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be shared by the University and the employees.

Voluntary Dental Benefits
[See Attachment #4]

Component Program:	University of Richmond Voluntary Dental Insurance Program
Health Care Reform Status:	Not applicable. Even though the Dental Plan voluntarily complies with certain HIPAA mandates, the Dental Plan is intended to be a HIPAA-excepted benefit, particularly for the purposes of health care reform.
Insured by:	Anthem Blue Cross and Blue Shield
Claims Administered by:	Anthem Dental P.O. Box 9274 Oxnard, CA 93031 Telephone Number: (800) 453-3622
COBRA Administered by:	Flores & Associates P.O. Box 31397 Charlotte, NC 28231-1397 Telephone Number: (800) 532-3327
Administration Other than Claims and COBRA:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be paid entirely by the employees.

Vision Benefits [See Attachment #14]	
Component Program:	University of Richmond Voluntary Vision Insurance Program
Health Care Reform Status:	Not applicable.
Insured by:	UniCare Life & Health Insurance Company
Claims Administered by:	UniView Vision Attn: Out of Network Claims P.O. Box 8504 Mason, OH 45040-7111 Phone (888)-884-8428
Administration Other than Claims:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be paid entirely by the employees.

Basic Life and AD&D Benefits [See Attachments #5 and #6]	
Component Programs:	Basic Life Insurance Plan and Accidental Death & Dismemberment Insurance Plan
Health Care Reform Status:	Not applicable.
Insured by:	Life Insurance Company of North America Life Insurance Group Policy FLX-960295 AD&D Group Policy OK-963781
Claims Administered by:	Cigna Group Operations Claims 2000 Park Lane Drive Pittsburgh, PA 15275 Telephone Number: (800) 238-2125
Administration Other than Claims:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be paid entirely by the University.

Long-Term Disability Benefits
[See Attachment #7]

Component Program:	Long-Term Disability Insurance Plan
Health Care Reform Status:	Not applicable.
Insured by:	Life Insurance Company of North America Group Policy LK-960276
Claims Administered by:	Cigna Group Operations Claims 2000 Park Lane Drive Pittsburgh, PA 15275 Telephone Number: (800) 238-2125
Administration Other than Claims:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be paid entirely by the University.

Short-Term Disability Plan for Faculty and Staff
[See Attachment #8]

Component Program:	Cigna Short-Term Disability Plan for Faculty and Staff
Health Care Reform Status:	Not applicable.
Insured by:	This Component Program is self-funded by the University.
Claims Administered by:	Cigna Group Operations Claims 2000 Park Lane Drive Pittsburgh, PA 15275 Telephone Number: (800) 238-2125
Administration Other than Claims:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be paid entirely by the University.

Employee Assistance Benefits
[See Attachment #9]

Component Program:	Employee Assistance Program
Health Care Reform Status:	This Component Program is not a grandfathered group health plan for purposes of health care reform.
Insured by:	Cigna
Claims Administered by:	Cigna Healthcare P.O. Box 182223 Chattanooga, TN 37422-7223
COBRA Administered by:	Flores & Associates P.O. Box 31397 Charlotte, NC 28231-1397 Telephone Number: (800) 532-3327
Administration Other than Claims and COBRA:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be paid entirely by the University.

Post-65 Retiree Medical Benefits – Open Plan
[See Attachment #10]

Component Program:	Post-Retirement Medical Benefits Program
Health Care Reform Status:	Not applicable.
Insured by:	This Component Program is self-funded by the University.
Medical Claims Administered by:	Humana P.O. Box 14601 Lexington, KY 40512-4601 Customer Service: (866) 396-8810 Pharmacist/Physician Rx Inquiries: (800) 865-8715
Prescription Drug Claims Administered by:	Humana P.O. Box 14601 Lexington, KY 40512-4601 Customer Service: (866) 396-8810 Pharmacist/Physician Rx Inquiries: (800) 865-8715
Administration Other than Claims:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be shared by the University and the employees.

Post-65 Retiree Medical Benefits – Closed Plan
[See Attachment #11]

Component Program:	Closed Retiree Medical Benefits Program
Health Care Reform Status:	Not applicable.
Insured by:	This Component Program is self-funded by the University.
Medical Claims Administered by:	Humana P.O. Box 14601 Lexington, KY 40512-4601 Customer Service: (866) 396-8810 Pharmacist/Physician Rx Inquiries: (800) 865-8715
Prescription Drug Claims Administered by:	Humana P.O. Box 14601 Lexington, KY 40512-4601 Customer Service: (866) 396-8810 Pharmacist/Physician Rx Inquiries: (800) 865-8715
Administration Other than Claims:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be paid entirely by the University.

Disabled Employee Medical Benefits
[See Attachment #12]

Component Program:	Disabled Employee Medicare Supplement Plan
Health Care Reform Status:	Not applicable.
Insured by:	Anthem Blue Cross and Blue Shield
Medical Claims Administered by:	Anthem Blue Cross and Blue Shield P.O. Box 27401 Richmond, VA 23279 Telephone Number: (800) 451-0361
Administration Other than Claims:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be paid entirely by the University.

Supplemental Life Insurance Benefits
[See Attachment #13]

Component Program:	Voluntary Supplemental Life Insurance Program
Health Care Reform Status:	Not applicable.
Insured by:	Life Insurance Company of North America
Claims Administered by:	Cigna Group Operations Claims 2000 Park Lane Drive, Pittsburgh, PA 15275 Telephone Number: (800) 238-2125
Administration Other than Claims:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be paid entirely by the employees.

Medical Reimbursement Benefits
[See Attachment #15]

Component Program:	Medical Flexible Spending Account Plan
Health Care Reform Status:	Not applicable.
Insured by:	This option is self-funded by the University.
Claims and COBRA Administered by:	Flores & Associates P.O. Box 31397 Charlotte, NC 28231-1397 Telephone Number: (800) 532-3327
Administration Other than Claims and COBRA:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be paid entirely by the employees.

Dependent Care Reimbursement Benefits
[See Attachment #15]

Component Program:	Dependent Care Assistance Program
Health Care Reform Status:	Not applicable.
Insured by:	This option is self-funded by the University.
Claims Administered by:	Flores & Associates P.O. Box 31397 Charlotte, NC 28231-1397 Telephone Number: (800) 532-3327
Administration Other than Claims:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be paid entirely by the employees.

Group Legal Services Plan [See Attachment #16]	
Component Program:	University of Richmond Group Legal Services Plan
Health Care Reform Status:	Not applicable.
Insured by:	Legal Resources
Claims Administered by:	Legal Resources 830 Southlake Blvd., Suite 2B Richmond, VA 23236 Telephone Number: (804) 897-1700
Administration Other than Claims:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be paid entirely by the employees.

Voluntary Accidental Injury Insurance
[See Attachment #17]

Component Program:	Voluntary Accidental Injury Insurance
Health Care Reform Status:	Not applicable.
Insured by:	Life Insurance Company of North America
Claims Administered by:	Cigna Phoenix Claims Services P.O. Box 55290 Phoenix, AZ 85078 Telephone Number: (800) 754-3207 Fax: (860) 730-6460
Administration Other than Claims:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be paid entirely by the employees.

Voluntary Hospital Indemnity Insurance
[See Attachment #18]

Component Program:	Voluntary Hospital Indemnity Insurance
Health Care Reform Status:	Not applicable.
Insured by:	Life Insurance Company of North America
Claims Administered by:	Cigna Phoenix Claims Services P.O. Box 55290 Phoenix, AZ 85078 Telephone Number: (800)754-3207 Fax: (860) 730-6460
Administration Other than Claims:	Human Resources University of Richmond 112 Weinstein Hall University of Richmond, VA 23173 Telephone Number: (804) 289-8747
Sources of Contributions:	The cost of the benefits will be paid entirely by the employees.

ATTACHMENT #1
UNIVERSITY OF RICHMOND MEDICAL PLAN
CIGNA TRADITIONAL PLAN

Evidence of Coverage available at:
<https://hr.richmond.edu/benefits/common/traditional-plan-booklet.pdf>

ATTACHMENT #2
UNIVERSITY OF RICHMOND MEDICAL PLAN
\$1,750 HIGH DEDUCTIBLE HEALTH PLAN

Evidence of Coverage available at:
<https://hr.richmond.edu/benefits/common/hdhp-1750-plan-booklet.pdf>

ATTACHMENT #3
UNIVERSITY OF RICHMOND MEDICAL PLAN
\$4,000 HIGH DEDUCTIBLE HEALTH PLAN

Evidence of Coverage available at:
<https://hr.richmond.edu/benefits/common/hdhp-4000-plan-booklet.pdf>

ATTACHMENT #4
UNIVERSITY OF RICHMOND VOLUNTARY DENTAL INSURANCE PROGRAM
EVIDENCE OF COVERAGE

Evidence of Coverage available at:
<https://hr.richmond.edu/benefits/common/insurance/dental-plan.pdf>

ATTACHMENT #5
UNIVERSITY OF RICHMOND GROUP LIFE INSURANCE
BASIC CERTIFICATE OF COVERAGE

Certificate of Coverage available at:
<https://hr.richmond.edu/benefits/common/basic-life-certificate.pdf>

ATTACHMENT #6
UNIVERSITY OF RICHMOND GROUP ACCIDENT INSURANCE
CERTIFICATE OF COVERAGE

Certificate of Coverage available at:
<https://hr.richmond.edu/benefits/insurance/pdf/accident-employee-certificate.pdf>

ATTACHMENT #7

**UNIVERSITY OF RICHMOND LONG-TERM DISABILITY INSURANCE PLAN
CERTIFICATE OF COVERAGE**

Certificate of Coverage available at:

<https://hr.richmond.edu/benefits/common/insurance/ltd-certificate.pdf>

ATTACHMENT #8

**CIGNA SHORT-TERM DISABILITY PLAN
FOR FACULTY AND STAFF SUMMARY**

Summary available at:

Staff:

<https://hr.richmond.edu/benefits/insurance/pdf/std-staff-summary-plan-description.pdf>

Faculty:

<https://hr.richmond.edu/benefits/insurance/pdf/std-faculty-summary-plan-description.pdf>

ATTACHMENT #9

UNIVERSITY OF RICHMOND EMPLOYEE ASSISTANCE PROGRAM SUMMARY

Description and summary available at:

<https://hr.richmond.edu/benefits/work-life/employee-assistance/index.html>

ATTACHMENT #10

**UNIVERSITY OF RICHMOND PRE-65 RETIREE MEDICAL BENEFITS PROGRAM AND
POST-RETIREMENT MEDICAL BENEFITS PROGRAM SUMMARY**

Summary available at:

<https://hr.richmond.edu/retirees/insurance.html>

ATTACHMENT #11

**UNIVERSITY OF RICHMOND CLOSED RETIREE MEDICAL
BENEFITS PROGRAM SUMMARY**

Summary available at:

<https://hr.richmond.edu/benefits/common/medicare-supplement-coverage.pdf>

ATTACHMENT #12

**UNIVERSITY OF RICHMOND DISABLED EMPLOYEE
MEDICARE SUPPLEMENT PLAN**

Summary of Coverage available at:

<https://hr.richmond.edu/benefits/common/medicare-supplement-coverage.pdf>

ATTACHMENT #13

**UNIVERSITY OF RICHMOND VOLUNTARY SUPPLEMENTAL LIFE INSURANCE
PROGRAM CERTIFICATE OF COVERAGE**

Certificate of Coverage available at:

<https://hr.richmond.edu/benefits/insurance/pdf/voluntary-life-employee-certificate.pdf>

ATTACHMENT #14

UNIVERSITY OF RICHMOND VOLUNTARY VISION

Documents available at:

<https://hr.richmond.edu/benefits/insurance/vision.html>

ATTACHMENT #15

UNIVERSITY OF RICHMOND FLEXIBLE BENEFIT PLAN

Documents available at:

<https://hr.richmond.edu/benefits/work-life/flexible-spending/index.html>

HSA information available at:

<https://hr.richmond.edu/benefits/insurance/medical-plans/hdhp/health-savings-account.html>

ATTACHMENT #16

UNIVERSITY OF RICHMOND GROUP LEGAL SERVICES PLAN

Summary available at:

<https://hr.richmond.edu/benefits/work-life/legal.html>

ATTACHMENT #17

VOLUNTARY ACCIDENTAL INJURY INSURANCE POLICY

Summary available at:

<https://hr.richmond.edu/benefits/insurance/medical-plans/pdf/SBC-accidental-injury-insurance.pdf>

ATTACHMENT #18
VOLUNTARY HOSPITAL INDEMNITY INSURANCE POLICY

Summary available at:

<https://hr.richmond.edu/benefits/insurance/medical-plans/pdf/SBC-hospital-care-coverage.pdf>

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