

DREXEL UNIVERSITY HEALTH
AND WELFARE PLAN AND
SUMMARY PLAN DESCRIPTION

As of January 1, 2012

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INTRODUCTION

Drexel University (the "University") maintains the Drexel University Health and Welfare Plan (the "Plan"). This document describes the Plan as in effect as of January 1, 2012.

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

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

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

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

PURPOSE OF THE PLAN

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

Core Benefits

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

- Basic Life and Personal Accident Coverage
- Long-Term Disability Coverage
- Business Travel Accident Coverage
- Employee Assistance Program Coverage
- Tuition Remission Coverage
- Tuition Exchange Coverage
- Health Advocate Coverage

Subsidized Benefits

If you are an eligible employee, you may enroll in the following subsidized benefits (subject to any applicable eligibility requirements described below), which require an employee contribution:

- Medical Coverage (including prescription drug coverage)
- Dental Coverage
- Vision Coverage

Voluntary Benefits

The University also offers the following voluntary, or optional, insurance and other coverage:

- Supplemental Life Coverage
- Supplemental Personal Accident Coverage
- Voluntary Short-Term Disability Coverage
- Pre-Tax Transportation Program

The University also offers the following insurance coverage: Long-Term Care Coverage (John Hancock), Group Legal Coverage (Hyatt Legal), Auto and Homeowner's Insurance (Liberty Mutual) and Supplemental Medical Coverage (AFLAC). Unlike the other benefits offered by the University, the University does not have any role in administering these insurance products other than to remit your payroll deduction contributions to the appropriate vendors. These benefits are offered for your convenience only and the arrangements are not subject to ERISA. Participation is completely voluntary. Please refer to the University's Web site for more information.

The University also offers flexible spending accounts for reimbursement of certain eligible health care and dependent care expenses on a pre-tax basis. For information about the University's flexible spending accounts, please refer to the Drexel University Cafeteria Plan and Summary Plan Description.

Retiree Benefits

If you are an eligible retiree, you may elect Medical Coverage for yourself and your spouse until you reach age 65. Please note, however, that you may not be eligible for all of the same Medical Coverage options that are available to eligible employees. The University will pay 50% of the monthly premium for you and your spouse of record at the time you retire up to a maximum of \$400 each. Dental and Vision Coverage is available, although you must pay the full cost of such coverage. Basic life insurance benefits are provided to you automatically. Tuition remission coverage is available for eligible retirees and their spouses/domestic partners and dependent children at the level the retiree was entitled on the date of retirement.

Retiree benefits for retirees who have attained age 65 are described in the Drexel University Post-65 Retiree Medical Plan and Summary Plan Description.

ELIGIBILITY AND PARTICIPATION

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

Eligible Employees

All full-time staff working a minimum of 40 hours per week and faculty working 12 or more credit hours in three or more quarters are eligible to participate in Core, Subsidized and Voluntary Benefits. Part-time staff working at least 20 hours a week and faculty with at least a 50% appointment are eligible to participate in Subsidized and Voluntary Benefits, as well as certain Core Benefits (Business Travel Accident Coverage, Employee Assistance Program Coverage and Health Advocate Coverage only). All regular full-time and part-time employees are eligible to participate in Voluntary Benefits. The following individuals are ineligible to participate in the Plan: **(1)** temporary employees, **(2)** those individuals who perform services for the University pursuant to an arrangement with a leasing organization, including but not limited to "leased employees," **(3)** those individuals who are not on the University payroll (such as consultants and independent contractors), whether or not they are later determined to be employees of the University, and **(4)** other non-regular employees (such as adjunct faculty members) as determined in accordance with the University's personnel policies and practices.

Eligible Dependents for Medical Coverage

If you are an eligible employee, you may elect Medical Coverage for your eligible dependents provided you choose coverage for yourself. Your eligible spouse and children automatically receive Employee Assistance Program Coverage and Health Advocate Coverage.

- Spouse - A spouse is the individual to whom you are legally married. This includes a "common law" spouse if you reside in a state that recognizes common law marriage, provided you complete the necessary forms provided by the Plan Administrator.

Domestic Partner – A domestic partner is the same-sex individual with whom you are in a committed relationship for an indefinite period. You must complete the "Domestic Partner Affidavit for Drexel Employees" and it must be approved by the University for your domestic partner to become eligible for benefits under the Plan. The University may request that you furnish additional information about your domestic partnership at any time.

Child - A child is a child who has not yet attained age 26. In addition, certain unmarried children may be covered beyond age 26 if they are unable to support themselves due to physical disability or mental disability which occurred prior to age 19, if they were covered under the Plan prior to attaining age 26. The following children may qualify for Medical Coverage under the Plan:

- a natural born child;
- a legally adopted child or a child placed with you for adoption;
- a stepchild living with you;
- a child who is under your legal guardianship;
- a same-sex domestic partner's child; or
- a foster child.

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

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

Eligible Dependents for Dental, Vision and Life Insurance Coverage

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

- Spouse - A spouse is the individual to whom you are legally married. This includes a "common law" spouse if you reside in a state that recognizes common law marriage; provided you complete the necessary forms provided by the Plan Administrator.

Domestic Partner – A domestic partner is the same-sex individual with whom you are in a committed relationship for an indefinite period. You must complete the "Domestic Partner Affidavit for Drexel Employees" and it must be approved by the University for your domestic partner to become eligible for benefits under the Plan. The University may request that you furnish additional information about your domestic partnership at any time.

Dependent Child - A dependent child is an unmarried child to age 19 (or to age 23 if regularly attending school on a full-time basis) who is dependent on you for support and maintenance. In addition, certain children may be covered beyond age 19 if they are unable to support themselves due to physical disability or mental disability, if they were covered under the Plan prior to attaining age 19. The following children may qualify as dependents:

- a natural born child;
- a legally adopted child or a child placed with you for adoption;
- a stepchild living with you;
- a child who is under your legal guardianship;
- a same-sex domestic partner's child; or
- a foster child.

Some state laws require that the Plan continue to provide Dental and Vision Coverage after a dependent has attained age 19 or 23. Please refer to the descriptive information provided by the insurance companies listed in Appendix A for more information.

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

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

Participation for Eligible Employees

If you are an eligible employee, you may elect to participate in the Plan as of the first of the month on or following your date of hire. (If you are hired on the first of the month, you may elect to participate in the Plan as of your date of hire). To become a participant, you must follow the enrollment process prescribed by the Plan Administrator and authorize and pay any required contribution(s). If dependent coverage is available (and elected), this dependent coverage will begin when your coverage begins. Once you make an election to participate in the Plan, you may change that election only (1) if you have a change in status, as described below under CHANGING YOUR ELECTION, or (2) during an open enrollment period at then applicable rates. If you fail to make an election for benefits or opt-out of benefits upon your initial eligibility for coverage, you will be automatically enrolled in employee-only Medical Coverage selected by the University as the Plan's default coverage. If you fail to make an election for benefits during the open enrollment period preceding any subsequent Plan Year, you will be deemed to have elected to maintain the same benefit coverage elections (at the applicable rates), with the exception of the flexible spending accounts described in the Drexel University Cafeteria Plan and Summary Plan Description. Therefore, it is extremely important that you enroll in the Plan within the time period prescribed by the Plan Administrator.

Resumption of Participation

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

Special Provisions for Eligible Retirees and their Spouses

All full-time employees who have completed 10 or more years of full-time consecutive service after the age of 45 may elect to continue health coverage (medical, dental and vision) under the Plan until they reach age 65. Full-time status is determined in accordance with the University's personnel policies and practices in force at the time of the determination of eligibility. If you are an eligible retiree, you may also elect to continue coverage for your spouse and same-sex domestic partner of record at the time of your retirement.

If you elect to continue your Dental and Vision Coverage during your retirement, you must pay the full cost of such coverage.

CESSATION OF PARTICIPATION

Cessation of Participation for Eligible Employees and Eligible Retirees

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

- the date on which the Plan terminates,

Participation for Eligible Employees

If you are an eligible employee, you may elect to participate in the Plan as of the first of the month on or following your date of hire. To become a participant, you must follow the enrollment process prescribed by the Plan Administrator and authorize and pay any required contribution(s). If dependent coverage is available (and elected), this dependent coverage will begin when your coverage begins. Once you make an election to participate in the Plan, you may change that election only (1) if you have a change in status, as described below under CHANGING YOUR ELECTION, or (2) during an open enrollment period at then applicable rates. If you fail to make an election for benefits or opt-out of benefits upon your initial eligibility for coverage, you will be automatically enrolled in employee-only Medical Coverage selected by the University as the Plan's default coverage. If you fail to make an election for benefits during the open enrollment period preceding any subsequent Plan Year, you will be deemed to have elected to maintain the same benefit coverage elections (at the applicable rates), with the exception of the flexible spending accounts described in the Drexel University Cafeteria Plan and Summary Plan Description. Therefore, it is extremely important that you enroll in the Plan within the time period prescribed by the Plan Administrator.

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Special Provisions for Eligible Retirees and their Spouses

All full-time employees who have completed 10 or more years of full-time consecutive service after the age of 45 may elect to continue health coverage (medical, dental and vision) under the Plan until they reach age 65. Full-time status is determined in accordance with the University's personnel policies and practices in force at the time of the determination of eligibility. If you are an eligible retiree, you may also elect to continue coverage for your spouse and same-sex domestic partner of record at the time of your retirement. No retiree coverage is provided to domestic partners under this Plan or the Drexel University Post-65 Retiree Medical Plan once the domestic partner attains age 65.

If you elect to continue your Dental and Vision Coverage during your retirement, you must pay the full cost of such coverage.

CESSATION OF PARTICIPATION

Cessation of Participation for Eligible Employees and Eligible Retirees

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

- the date on which the Plan terminates,
- the date on which you cease to be an eligible employee or eligible retiree, whichever applies,

- the first day of any Plan Year in which you elect not to participate,
- the date as of which you fail to make a required contribution, or
- the date as of which you revoke your election of coverage, as described below under COVERAGE OPTIONS AND ENROLLMENT.

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

Cessation of Participation for Dependents

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

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

Authorized Leaves of Absence

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

Leave Under Family Medical Leave Act (FMLA)

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

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

Military Leave

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

COST OF COVERAGE

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

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

If your same-sex domestic partner and/or your domestic partner's children are covered under the Plan's health coverage options (medical, dental and vision), such benefits cannot be paid on a pre-tax basis in accordance with current IRS regulations unless such individuals are claimed as your dependents on your federal income tax return. The value of the coverage is "imputed income" and taxable to you. The amount of the imputed income depends on the level of coverage that you select. Imputed income increases your taxable gross income as well as the Social Security and Medicare taxes withheld from your pay and is reported on your annual Form W-2.

The University shares the cost of coverage for medical options under this Plan with eligible retirees. To the extent you are required to make contributions, you must pay the difference between the monthly cost for the medical option in which you are enrolled and the University's retiree allowance. The University sets the level of any retiree contributions. The University reserves the right to change the level of retiree contributions at any time.

COVERAGE OPTIONS AND ENROLLMENT

During each annual open enrollment period, you will be given the opportunity to make your benefit choices for the upcoming Plan Year (January 1 to December 31). Except for the University's flexible spending accounts (as described in the Drexel University Cafeteria Plan and Summary Plan Description) and as otherwise determined by the University, if you do not elect to change your selection from the previous year, the University assumes that you want to continue under the same option(s), subject to the payment of the applicable contribution(s). The availability of a particular option may be governed by an insurance contract or other provider agreement that contains specific eligibility guidelines or other criteria not specifically mentioned in this booklet.

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

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

- Change in Marital Status- a change in your legal marital status (such as marriage, legal separation, annulment, divorce or death of your spouse),
- Change in Number of Dependents- a change in the number of your dependents (such as the birth of a child, adoption or placement for adoption of a dependent, or death of a dependent),

Change in Employment Status - any of the following events that change the employment status of you, your spouse or your dependent that affects benefit eligibility under an employee benefit plan (including this Plan) of you, your spouse or your dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, or part-time and full-time; incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular benefit under this or another plan,

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

- Change in Residence- a change in your, your spouse's or your dependent's place of residence.

If a Life Event occurs, you must inform the Plan Administrator and complete a Change of Status form within 31 days of the Life Event. Your coverage change will be effective on the first day of the month after you provide timely notice to the Plan Administrator. However, if the Life Event is a birth, adoption, or placement for adoption of a dependent child, coverage will be retroactively provided to the date of the event, again subject to timely notice of the event.

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

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

Special Enrollment Rights. If you, your spouse and/or a dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (*i.e.*, due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible dependents who lost such coverage. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your spouse, and your newly acquired dependents; provided, that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Furthermore, if you, your spouse and/or a dependent loses eligibility for coverage under Medicaid or a state's Children's Health Insurance Program ("CHIP"), or you or your dependent become eligible for state premium assistance under

Medicaid or CHIP, you may enroll in medical coverage under this Plan if you notify the University within 60 days of the event. Please refer to the applicable medical coverage booklet for an explanation of special enrollment rights.

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

End of Domestic Partnership. If your domestic partnership ends or you otherwise no longer meet the Plan's eligibility requirements, you cannot cover your domestic partner and his or her otherwise eligible children. Your domestic partner and his or her children, if covered by the Plan prior to the end of the partnership, will be eligible for COBRA continuation coverage upon the termination of coverage under the Plan. Once you drop coverage for a partner, you must fulfill all of the applicable criteria requirements before adding the same or another eligible partner to your coverage.

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

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

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

BENEFITS

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

Medical Coverage (including prescription drug coverage)

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

Special Rules Related to Pregnancy and Childbirth. The Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section, or require that a health care provider obtain authorization from the Plan or any insurance issuer (including an HMO) for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

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

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

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

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

Nondiscrimination Based on Health Factor. The Plan generally may not establish any rule for eligibility to enroll in the Plan (including continued eligibility) that discriminates against an employee or dependent because of a health factor or charge higher premiums on account of a health factor. "Health factors" include with respect to an individual (i) health status; (ii) medical condition; (iii) claims experience; (iv) receipt of health care; (v) medical history; (vi) genetic information; (vii) evidence of insurability or (viii) disability. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits the University from discriminating against you or your eligible dependents on the basis of genetic information.

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

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

Patient Protection and Affordable Care Act ("Health Care Reform"). The Medical Coverage under the Plan complies with the applicable provisions of Health Care Reform, which generally became effective as of January 1, 2011. The Plan does not apply any lifetime or unreasonable annual dollar limits on essential benefits and certain preventive care services are covered without cost sharing.

Privacy and Security of Health Information. The receipt, use and disclosure of protected health information, as well as the security of protected health information transmitted electronically, is governed by regulations issued under the Health Insurance Portability and Accountability Act (commonly referred to as "HIPAA"). In accordance with these regulations, the Plan Administrator, certain employees working with, and on behalf of, the Plan and the Plan's business associates may receive, use and disclose protected health information in order to carry out the payment, treatment and health care operations under of the Plan. These entities and individuals may use protected health information for such purposes without your authorization. If your protected health information is used or disclosed for any other purpose (other than as

specifically required or authorized under HIPAA), the Plan must first obtain your written authorization for such use or disclosure. Refer to Appendix C and the Plan's Privacy Notice for more information on medical records privacy. The Privacy Notice is available on the University's Web site or from the Human Resources Department.

Dental Coverage

You have the option to purchase Dental Coverage for yourself and your dependents. There is an annual per person and family deductible and an annual maximum benefit for this coverage.

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

Vision Coverage

You have the option to purchase Vision Coverage for yourself and your dependents to cover such services as eye exams, frames and lenses and contact lenses. There are copayments for certain services.

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

Employee Assistance Program (EAP) Coverage

You automatically receive coverage under the Employee Assistance Program to aid you and your dependents in dealing with personal and work-related problems, such as parenting, retirement, health and wellness and emotional well-being. EAP coverage is not available under the Plan if you are an eligible retiree.

Health Advocate Coverage

The Personal Health Advocate is a trained professional, typically a registered nurse, who can help you navigate the intricacies of the healthcare system. Services include helping employees understand tests, treatments and medications, facilitating the transfer of medical records, coordinating and making arrangements for diagnostic tests and arranging hospice and other services. The Health Advocate can be accessed 24 hours a day, 7 days a week. Refer to Appendix A for contact information. The Health Advocate is not available to retirees.

Life and Accident Coverage

Basic Life Insurance - The University provides two times your annual salary to a maximum benefit of \$500,000 of basic life and personal accident coverage. If the value of your life insurance exceeds \$50,000, you have the option of limiting your coverage to \$50,000 to avoid imputed income, as described below. If you limit the amount of your insurance and then later decide that you would like to elect two times your annual salary, you will be required to show proof of insurability.

The University provides \$4,500 of basic life insurance to eligible retirees.

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

Supplemental Life Insurance - If you are an eligible employee and you want life insurance coverage in addition to basic life insurance, you may elect to purchase between one and four times your annual salary in coverage up to a maximum benefit of \$2,500,000. The premiums for this coverage will be made through payroll deductions. You can elect spousal/domestic partner coverage up to \$150,000 and dependent child coverage of \$5,000 or \$10,000. You also can elect to purchase supplemental personal accident insurance for yourself, your spouse, your domestic partner and/or dependent children.

Long-Term Disability Insurance

If you are an eligible employee and you are unable to work due to non-work-related illness or injury, you may be eligible to receive long-term disability ("LTD") benefits. The cost of long-term disability coverage is paid by the University. If you are determined by the insurance company listed in Appendix A to be disabled within the meaning of the contract, benefits commence once you have been absent from work due to illness or injury for a period in excess of ninety continuous days and will be equal to 60% of your monthly earnings up to a maximum monthly dollar amount of \$20,000. Your LTD benefits may be offset by other sources of income and disability earnings, including but not limited to any payments under any state compulsory benefit law, other group insurance plan or sick leave, salary continuance plan provided by or through the University or University-sponsored pension income (including disability and/or other retirement income). The duration of benefit payments may be limited in certain circumstances. If you terminate your employment with the University, your LTD coverage will be terminated on your termination date. Please refer to the descriptive information provided by the insurance company listed in Appendix A for more information.

During periods in which you receive LTD benefits, you will be billed directly by the University to continue your Medical, Dental and Vision Coverage. If you fail to pay premiums as required by the University, your Medical, Dental and Vision Coverage will be terminated and you will then be eligible to elect COBRA continuation coverage, of which you are responsible for 102% of the total premium.

Business Travel Accident Insurance

If you are an eligible employee, you automatically receive business travel accident protection if you die or become seriously injured while traveling on University business. The amount of coverage is one times your annual salary, up to a maximum of \$500,000 with a minimum of \$100,000.

Tuition Remission

If you are an eligible employee, either full or partial tuition remission is provided to you and your eligible spouse, domestic partner and dependent children at the University. Employees on leave (other than sabbaticals) are not eligible for tuition remission for themselves. Schools and programs not eligible for tuition remission include, but are not limited to, the College of

Medicine M.D. program, the Executive MBA program and the MBA online program, any degree or program of the College of Law, the Ed.D. in Educational Leadership and Management, or other programs that require a flat fee which constitutes full time enrollment. Courses must be taken outside of a staff member's normal work schedule.

Full-time employees are eligible for 100% remission for up to three (3) undergraduate or two (2) graduate courses. Their dependents can be eligible for 20 to 100% remission based on the employee's length of service with the University.

Employees are fully responsible for any tax liability incurred as a result of these benefits. If an employee enrolls in graduate coursework with a value of more than \$5,250, any excess is taxable.

Tuition remission does not cover any fees or expenses associated with being a student at the University (*i.e.*, general fee, student health fee, room and board, the cost of required travel, laptop computers, etc.).

Tuition remission is available for eligible retirees, their spouses, domestic partners, and dependent children at the level the retiree was entitled on the date of retirement.

Please refer to the University's Tuition Remission Policy for further information on requirements, restrictions and the application procedure for tuition remission.

Tuition Exchange

Tuition Exchange ("TE") is a tuition scholarship program (for dependent, natural born or adopted children of full-time employees only) at schools other than the University. Under the National Tuition Exchange Program, attendance at other member schools may be available, depending on various factors. The number of TE slots available to employees each year is based on Drexel's credit balance within the consortium (not to exceed eight). Therefore, it is possible that there will be a limit on the number of employees who can use the program from year to year. Similarly, neither the acceptance at member institutions nor the award of TE is guaranteed under the TE program. For this reason, parents are encouraged to view TE as one of their many options in funding their child's education, rather than the sole option. Please refer to the University's Tuition Exchange Policy for further information.

Voluntary Short-Term Disability Coverage

You can elect to purchase short-term disability coverage which provides you with a benefit of 60% of your weekly base pay when you are unable to work at the University as a result of an approved disability. Benefits begin following 30 days of continuous disability and the exhaustion of sick time. You must pay the full amount of the premium for this coverage. Please refer to the "Drexel Employee Short Term Disability" instruction sheet for more information.

Pre-Tax Transportation Program

The Pre-Tax Transportation Program allows you to pay for eligible transit and parking expenses through pre-tax payroll deductions up to the maximum amount established by the Internal

Revenue Service each calendar year. The Program is intended to qualify as a "qualified transportation fringe" benefit plan under Internal Revenue Code section 132(f). You may change your election on a monthly basis, provided you do so within the required timeframe.

LOSS OF BENEFITS

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

CLAIMS AND APPEALS PROCEDURES

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

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

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

enough information to allow the Claims Administrator to process the claim, you will be given an opportunity to provide the missing information. .

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

IMPORTANT: The procedures set forth below do not apply to Health Advocate Coverage, Tuition Remission Coverage, Tuition Exchange Coverage or the Pre-Tax Transportation Program.

Claims Not Involving Health Benefits

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

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

relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the determination and that a copy of such rule will be provided to you free of charge at your request; and

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

determination and that a copy of such rule will be provided to you free of charge at your request; and

- *Statement of Right to Bring Action* - a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits.

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

Claims Involving Health Benefits

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

- Types of Claims - There are several different types of claims that you may bring under the Plan. The Plan's procedures for evaluating claims (for example, the time limits for responding to claims and appeals) depend upon the particular type of claim. The types of claims that you generally may bring under the Plan are as follows:
 - *Pre-Service Claim* - A "pre-service claim" is a claim for a particular benefit under the Plan that is conditioned upon receiving prior approval in advance of receiving the benefit. A pre-service claim must contain, at a minimum, the name of the individual for whom benefits are being claimed, a specific medical condition or symptom, and a specific treatment, service or product for which approval is being requested.

Post-Service Claim - A "post-service claim" is a claim for payment for a particular benefit or for a particular service after the benefit or service has been provided. A post-service claim must contain the information requested on a claim form provided by the applicable provider.
 - *Urgent Care Claim* - An "urgent care claim" is a claim for benefits or services involving a sudden and urgent need for such benefits or services. A claim will be considered to involve urgent care if the Claims Administrator or a physician with knowledge of your condition determines that the application of the claims review procedures for non-urgent claims (i) could seriously jeopardize your life or your health, or your ability to regain maximum function, or (ii) in your physician's opinion, would subject you to severe pain that cannot adequately be managed without the care or treatment that is the subject of the claim.

- *Concurrent Care Review Claim* - A "concurrent care review claim" is a claim relating to the continuation/reduction of an ongoing course of treatment.
- Time Periods for Responding to Initial Claims - If you bring a claim for benefits under the Plan, the Claims Administrator will respond to your claim within the following time periods:
 - *Post-Service Claim* - In the case of a post-service claim, the Claims Administrator shall respond to you within 30 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 30-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is necessary because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.

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

- *Concurrent Care Review Claim* - If the Plan has already approved an ongoing course of treatment for you and contemplates reducing or terminating the treatment, the Claims Administrator will notify you sufficiently in advance of the reduction or termination of treatment to allow you to appeal the Claims Administrator's decision and obtain a determination on review before the treatment is reduced or terminated.

- Notice and Information Contained in Notice Denying Initial Claim- If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally). This notice will include the following:
 - *Reason for the Denial* - the specific reason or reasons for the denial;
 - *Reference to Plan Provisions* - reference to the specific Plan provisions on which the denial is based;

Description of Additional Material - a description of any additional material or information necessary for you to perfect your claim and an explanation as to why such information is necessary;
 - *Description of Any Internal Rules* - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
 - *Description of Claims Appeals Procedures*- a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will include a statement that you are eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal and a description of any expedited review process for urgent care claims).

- Appealing a Denied Claim for Benefits - If the Claims Administrator denies your initial claim for benefits, you may appeal the denial by filing a written request (or an oral request in the case of an urgent care claim) with the Appeals Administrator within 180 days after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Appeals Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your appeal.

Time Periods for Responding to Appealed Claims - If you appeal a denied claim for benefits, the Appeals Administrator will respond to your claim within the following time periods:

Post-Service Claim - In the case of an appeal of a denied post-service claim, the Appeals Administrator shall respond to you within 60 days after receipt of the appeal.

- *Pre-Service Claim* - In the case of an appeal of a denied pre-service claim, the Appeals Administrator shall respond to you within 30 days after receipt of the appeal.
- *Urgent Care Claim* - In the case of an appeal of a denied urgent care claim, the Appeals Administrator shall respond to you within 72 hours after receipt of the appeal.
- *Concurrent Care Review Claim* - In the case of an appeal of a denied concurrent care review claim, the Appeals Administrator shall respond to you before the concurrent or ongoing treatment in question is reduced or terminated.

Notice and Information Contained in Notice Denying Appeal- If the Appeals Administrator denies your claim (in whole or in part), the Appeals Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally or via facsimile or other similarly expeditious means of communication). This notice will include the following:

- *Reason for the Denial* - the specific reason or reasons for the denial;
- *Reference to Plan Provisions*- reference to the specific Plan provisions on which the denial is based;
- *Statement of Entitlement to Documents* - a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits;
- *Description of Any Internal Rules* - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
- *Statement of Right to Bring Action* - a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits.

The decision of the Appeals Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you challenge the decision of the Appeals Administrator, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before you can pursue the claim in federal court. Facts and evidence that become

known to you after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

NOTE: Under Health Care Reform, beginning January 1, 2011, you are entitled to an independent external review of your medical and prescription drug claims if your appeal is denied. Contact the benefit provider directly for more information on the external review process for medical and prescription drug claims.

CONTINUATION OF COVERAGE UNDER COBRA

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

General Explanation of COBRA Continuation Coverage

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

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

Who Must Provide Notice When Coverage is Lost

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

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

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

PERSON AFFECTED (Qualified Beneficiary)	REASON FOR LOSS OF COVERAGE (Qualifying Event)	PERIOD OF CONTINUATION COVERAGE
Employee	Reduction in hours of employment Termination of employment for reasons other than gross misconduct	18 months* 18 months*
Covered Spouse or Domestic Partner of an Employee	Death of employee Divorce or legal separation from employee Employee becomes entitled to Medicare benefits Reduction in employee's hours of employment Termination of employee's employment for reasons other than gross misconduct	36 months 36 months 36 months 18 months* 18 months*
Covered Child of an Employee or Covered Domestic Partner's Child	Death of employee Divorce or legal separation of employee and spouse Employee becomes entitled to Medicare benefits Failure of child to qualify as a dependent under the Plan Reduction in employee's hours of employment Termination of employee's employment for reasons other than gross misconduct	36 months 36 months 36 months 36 months 18 months* 18 months*
<p>* The 18-month COBRA continuation coverage period will be extended to 29 months for all qualified beneficiaries if any qualified beneficiary is disabled under the Social Security laws at any time during the first 60 days of COBRA continuation coverage. To qualify for this extension, the qualified beneficiary must notify the Plan Administrator and provide proof that he or she is disabled under the Social Security laws before the expiration of the 18-month period. The Plan Administrator is permitted to charge a higher premium for COBRA continuation coverage during the 19th through 29th months. If the employee finds that he or she is no longer disabled, he or she must notify the Plan Administrator within 30 days of such a determination.</p>		

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

If You Elect to Continue Coverage

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

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

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

Coverage You May Elect

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

Coverage for Eligible Dependents

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

Changes to COBRA Continuation Coverage

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

If You Have Region-Specific Coverage

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

When COBRA Benefits End

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

- The person whose coverage is being continued fails to pay the premium on time;
- The person whose coverage is being continued becomes, after the date of the election of COBRA continuation coverage, covered under another employer's group health plan unless the other group health plan contains an exclusion or limitation with respect to a preexisting condition of the person (other than an exclusion or limitation that does not apply to (or is satisfied by) the person under applicable provisions of federal law);

The person whose coverage is being continued becomes, after the date of the election of COBRA continuation coverage, entitled to Medicare benefits;

In the case of a person whose coverage is being continued under the special extended coverage period for disabled individuals, it is determined that the disabled person is no longer disabled under the Social Security laws; or

- The University no longer maintains a group health plan covering any employee.

Two Qualifying Events

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

Continuation Coverage During Military Service

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

Conversion to an Individual Policy

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

PLAN ADMINISTRATOR

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

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

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

AMENDMENT OR TERMINATION OF THE PLAN

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

ADDITIONAL INFORMATION

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

Plan Name: Drexel University Health and Welfare Plan

Plan Number: 519

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

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

Drexel University
3201 Arch Street, Suite 430
Philadelphia, PA 19104-2762
(215) 895-2850

Employer Identification Number ("EIN"). The employer identification number assigned to the University by the IRS is 23-1352630.

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

Drexel University
3201 Arch Street, Suite 430
Philadelphia, PA 19104-2762
(215) 895-2850

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

Type of Plan. The Plan is a welfare benefit plan providing the following types of benefits: (1) medical coverage, (2) dental coverage, (3) EAP, (4) health advocacy coverage, (5) vision coverage, (6) life insurance (basic and AD&D, additional life), (7) dependent life insurance, (8) long-term disability insurance, (9) short-term disability benefits, and (10) business travel accident insurance. The benefits described in items (1), (2), (3) and (5) are provided under a "group health plan" within the meaning of ERISA. The Plan also provides tuition and transportation benefits.

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

Funding Medium. The benefits under the Plan are funded through direct payments from the general funds of the Plan Sponsor or one or more insurance contracts. The University establishes contribution rates based upon premium rates set by the insurance carriers and/or administrators. Contributions are made by employees, COBRA qualified beneficiaries, and the University. Periodically, dividends or refunds are received from the insurance carriers or administrators. These will be used to reduce University expenses.

THIRD PARTY LIABILITY

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

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

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

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

NO ASSIGNMENT OF BENEFITS

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER ("QMCSO")

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

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

- period of time the coverage is to be provided.

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

STATEMENT OF ERISA RIGHTS

IMPORTANT: The procedures set forth below do not apply to Health Advocate Coverage, Tuition Remission Coverage, Tuition Exchange Coverage, or the Pre-Tax Transportation Program.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Note that this Plan's Form 5500 filing includes information on the benefits set forth in the Drexel University Cafeteria Plan and the Drexel University Post-65 Retiree Medical Plan.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you

and other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

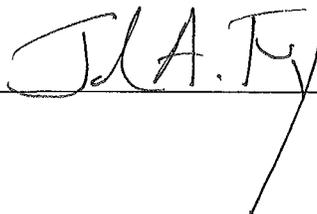
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

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

Drexel University herewith causes this Plan to be executed as of the 21:> day of Dec . 2011 by its duly authorized officer.

DREXEL UNIVERSITY

By:  _____

**APPENDIX A BENEFIT
PROVIDERS (As of
January 2011)**

Self-Insured Medical Coverage

Personal Choice
Independence Blue Cross
1901 Market Street
Philadelphia, PA 19103-1480

Keystone POS
Independence Blue Cross
1901 Market Street
Philadelphia, PA 19103-1480
1-800-275-2583

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

Eligible employees employed by the University in Sacramento, California cannot elect the Keystone POS medical coverage option under the Plan.

Insured Medical Coverage

Western Health Advantage
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

The University has contracted with the above insurance company to provide medical benefits and claim services under the Plan for certain employees employed by the University in Sacramento, California. Benefits are determined and are paid entirely by the insurance company and are guaranteed under the policy.

Prescription Drug Coverage

Medco
P.O. Box 14711
Lexington, KY 40512
1-800-864-1140

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

Dental Coverage

CIGNA Dental
P.O. Box 188037
Chattanooga, TN 37422-8037
1-800-244-6224

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

Vision Coverage

EyeMed Vision Care
P.O. Box 8504
Mason, OH 45040-7111
1-866-723-0514

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

EAP Coverage

Health Advocate
3043 Walton Road
Suite 150
Plymouth Meeting, PA 19462
1-866-695-8622

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

Health Advocate Coverage

Health Advocate
3043 Walton Road
Suite 150
Plymouth Meeting, PA 19462
1-866-695-8622

The University has contracted with the above provider to provide health advocacy services under the Plan. Benefits are determined entirely by the provider.

Long-Term Disability Coverage

The Hartford
200 Hopmeadow Street
Simsbury, CT 06089
1-800-741-4306

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

Life and Accident Coverage

The Hartford
200 Hopmeadow Street
Simsbury, CT 06089
1-888-563-1124

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

Business Travel Accident Coverage

CIGNA Corporation
1600 West Carson Street
Pittsburgh, PA 15219
1-800-238-2125

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

Short-Term Disability Coverage

The Hartford
200 Hopmeadow Street
Simsbury, CT 06089
1-800-741-4306

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

Tuition Remission Coverage and Tuition Exchange Coverage are administered by the University. The Pre-Tax Transportation Program is administered by Aon Hewitt.

APPENDIXB
CLAIMS ADMINISTRATORS AND APPEALS ADMINISTRATORS
(As of January 2011)

TYPE OF BENEFIT/PROVIDER	NAME AND ADDRESS OF CLAIMS ADMINISTRATOR	NAME AND ADDRESS OF APPEALS ADMINISTRATOR
Medical		
Personal Choice Flex Plan (PPO)	Personal Choice Independence Blue Cross P.O. Box 69352 Hanisburg, PA 17106-9352	IBC Member Appeals Unit P.O. Box 41820 Philadelphia, PA 19101-1820
Keystone Direct (POS)	Keystone Direct (POS) Independence Blue Cross P.O. Box 69353 Hanisburg, PA 17106-9352	KPOS Member Appeals Unit P.O. Box 41820 Philadelphia, PA 19101-1920
Western Health Advantage	Western Health Advantage 2349 Gateway Oaks Drive Suite 100 Sacramento, CA 95833	Western Health Advantage 2349 Gateway Oaks Drive Suite 100 Sacramento, CA 95833
Prescription Drug		
Medco	Medco P.O. Box 14711 Lexington, KY 40512	Medco P.O. Box 14711 Lexington, KY 40512
Vision		
EyeMed Vision Care	EyeMed Vision Care Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111	EyeMed Vision Care Attn: Appeals P.O. Box 8504 Mason, OH 45040-7111
Dental		
CIGNA	CIGNA Dental P.O. Box 188037 Chattanooga, TN 37422-8037	CIGNA Dental P.O. Box 188037 Chattanooga, TN 37422-8037
Employee Assistance		
Health Advocate	Health Advocate 3043 Walton Road Suite 150 Plymouth Meeting, PA 19462 1-866-695-8622	Health Advocate 3043 Walton Road Suite 150 Plymouth Meeting, PA 19462 1-866-695-8622
Long-Term Disability		
The Hartford	The Hartford Benefit Management Services P.O. Box 14306 Lexington, KY 40512-4306	The Hartford Benefit Management Services P.O. Box 14306 Lexington, KY 40512-4306

TYPE OF BENEFIT/PROVIDER	NAME AND ADDRESS OF CLAIMS ADMINISTRATOR	NAME AND ADDRESS OF APPEALS ADMINISTRATOR
Life and Accident		
The Hartford	The Hartford Benefit Management Services Maitland Claim Office P.O. Box 946790 Maitland, FL 32794-6790	The Hartford Benefit Management Services Maitland Claim Office P.O. Box 946790 Maitland, FL 32794-6790
Business Travel Accident		
CIGNA	CIGNA Corporation 1600 West Carson Street Pittsburgh, PA 15219	CIGNA Corporation 1600 West Carson Street Pittsburgh, PA 15219
Short-Term Disability		
The Hartford	The Hartford Benefit Management Services P.O. Box 14306 Lexington, KY 40512-4306	The Hmtford Benefit Management Services P.O. Box 14306 Lexington, KY 40512-4306

.APPENDIXC

HIPAA PRIVACY AND SECURITY AND PROTECTED HEALTH INFORMATION

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

The following provisions permit the Plan to disclose your protected health information ("PHI"), as defined in HIPAA, to the Plan Sponsor to the extent that such PHI is necessary for the Plan Sponsor to carry out its administrative functions related to the Plan. This Appendix C is effective April 14, 2003, and has been amended so as to comply with the Security Rule (as set forth in the final security regulations effective April 20, 2005) and the Health Information for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009 ("ARRA").

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

The Plan Sponsor needs access to PHI to:

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

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

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

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

- (c) The Plan and Plan Sponsor will work together to create new safeguards and procedures so as to prevent a future incident of noncompliance.
- (f) Breach of Unsecured Protected Health Information. Upon the discovery of a potential breach of PHI, the Plan Sponsor will determine whether the incident is an actual breach under ARRA, and comply with the timing, content and other breach notification requirements of ARRA. The Plan Sponsor will take appropriate measures to mitigate any harm that has resulted or may result from the breach and to prevent such a breach from occurring in the future.
- (g) Electronic PHI. The Plan Sponsor will take appropriate measures to maintain the confidentiality, integrity and availability of PHI that is stored or transmitted electronically ("Electronic PHI") by:
 - (1) implementing administrative, physical, and technical safeguards for Electronic PHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan;
 - (2) ensuring that the adequate separation between the Plan and the Plan Sponsor described in paragraph (d) is supported by reasonable and appropriate security measures;
 - (3) requiring any agents of the Plan who receive your Electronic PHI to abide by the Plan's security rules; and
 - (4) reporting to the Plan any security incident of which it becomes aware.

Employment records and Plan enrollment information are not considered electronic PHI.

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

Department of Health and Human Services for verification of the Plan's compliance with HIPAA.

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