

**The Saint Louis University  
Welfare Benefit Plan**

**Summary Plan Description**

**Effective August 1, 2021**

**THE SAINT LOUIS UNIVERSITY WELFARE BENEFIT PLAN  
SUMMARY PLAN DESCRIPTION**

**TABLE OF CONTENTS**

	<b>PAGE</b>
INTRODUCTION.....	1
ELIGIBILITY.....	2
Eligible Employees.....	2
Counting Hours of Service for Medical Coverage.....	3
Eligible Retirees.....	3
Eligible Dependents.....	4
Qualified Medical Child Support Order.....	4
ENROLLMENT.....	5
Initial Enrollment Period.....	5
Open Enrollment Period.....	5
Special Enrollment Period.....	6
PAYMENT OF PREMIUMS.....	6
PARTICIPATION.....	7
When Coverage Begins.....	7
Leaves of Absence.....	7
Sabbaticals.....	8
Rehires.....	8
CHANGING YOUR COVERAGE MID-YEAR.....	9
Change in Status Events.....	9
WHEN COVERAGE ENDS.....	10
ADDITIONAL RULES FOR GROUP HEALTH PLAN COMPONENTS.....	11
Family and Medical Leave Act (FMLA).....	11
Uniformed Services Employment and Reemployment Rights Act (USERRA).....	12
Consolidated Omnibus Budget Reconciliation Act (“COBRA”).....	12
COORDINATION OF BENEFITS.....	16
Coordination of Benefits With Medicare.....	17
Medicaid.....	18
CLAIMS, APPEALS AND EXTERNAL REVIEWS.....	18
Health Care Claims and Appeals.....	19
External Review (Medical Only).....	24
Disability Claims and Appeals.....	25
ERISA Benefits Other Than Health or Disability.....	28

RECOVERY AND REIMBURSEMENT .....	30
Refund of Overpayments.....	30
Misrepresentation.....	30
AMENDMENT OR TERMINATION OF THE PLAN .....	30
YOUR RIGHTS UNDER ERISA .....	30
ERISA PLAN INFORMATION .....	32
Plan Name and Number .....	32
Type of Plan.....	32
Plan Year .....	32
Plan Sponsor and Employer Identification Number.....	32
Plan Administrator .....	32
Funding.....	33
Agent for Service of Legal Process.....	33

## ***INTRODUCTION***

Saint Louis University (“University”) sponsors The Saint Louis University Welfare Benefit Plan (“Plan”) providing medical, dental, vision, long-term disability, basic and supplemental life and accidental death and dismemberment, business travel accident, legal and voluntary accident benefits (each a “Benefit Component”) to eligible employees of the University. However, the benefits available under the Plan (and eligibility criteria with respect to such benefits) may vary among different groups of employees. The Plan Administrator will communicate the benefits available to you when you first become eligible to participate in the Plan and during Open Enrollment.

Participation in a Plan does not give you the right to be retained in the service of the University nor does it entitle you to any benefits other than the benefits specifically provided for in a Benefit Component.

Each Benefit Component is summarized in a certificate of insurance booklet issued by an insurance company, a summary prepared specifically for the Benefit Component by a third-party administrator or the Plan Administrator, or another written governing document (each a “Benefit Booklet”). This document provides an overview of the Plan and addresses certain information that may not be covered in the Benefit Booklets. ***For this reason, it is important that you review both this document and the Benefit Booklets to fully understand the benefits available to you under the Benefit Components and your rights and obligations under the Plan with respect to such benefits.*** This document, together with each Benefit Booklet, is intended to serve as the summary plan description (SPD) required by ERISA for the applicable Benefit Component. In the event of a conflict between a provision in this document and a provision in a Benefit Booklet, this document will govern.

Most Benefit Booklets are available online at <https://www.slu.edu/human-resources/benefits/summary-plan-descriptions.php>. You can also obtain a copy of any Benefit Booklet free of charge by sending a written request to the Plan Administrator.

If you have any questions concerning your benefits, you should contact the Plan Administrator.

## ***ELIGIBILITY***

### **Eligible Employees**

You are eligible to participate in the Plan if you are classified by the University as:

- a regular full-time employee; or
- a member of the medical faculty with a joint appointment with the University and the Veteran's Administration who receives an annual salary of at least \$5,000 from the University;
- a tenured faculty member participating in approved phased retirement.

For eligibility purposes, a full-time employee is an employee who is scheduled to work at least 32 hours per week on a regular and continuous basis. However, as described in the "Counting Hours of Service for Medical Coverage" section, full-time employee status for participation in medical coverage is based on averaging at least 30 hours of service per week over a specified period.

*IMPORTANT NOTE: You should also consult each Benefit Booklet as it may include additional eligibility requirements (or exclusions) specific to that particular Benefit Component of the Plan. For example, eligibility for certain classes of employees to participate in life and AD&D benefits is subject to satisfaction of a service requirement and only employees who are citizens or permanent resident aliens of the United States are eligible for coverage. Refer to the applicable Benefits Booklet for more information.*

You are not eligible to participate in the Plan if:

- You are classified by the University as an independent contractor, consultant or other self-employed individual;
- You are employed through a temporary staffing agency or leasing organization and are not included in the University's regular payroll system;
- You are covered by a collective bargaining agreement (unless participation in the Plan or a Benefit Component is expressly provided thereunder);
- You are a non-resident alien performing services for the University outside the United States; or
- You are not legally authorized to work in the United States for the University.

In addition, your participation in the Plan (or any Benefit Component under a Plan) may be limited by the terms of any agreement pursuant to which you are engaged by the University.

If you are classified by the University as an independent contractor, consultant or other self-employed individual, you remain ineligible to participate in the Plan, even if a court, the Internal Revenue Service (IRS) or any other enforcement or regulatory authority finds that you should be considered a common-law employee, unless the University re-classifies you as a common-law employee.

## **Counting Hours of Service for Medical Coverage**

A new employee, who is reasonably expected at the time of hire to average at least 30 hours of service per week, will be offered medical coverage under the Plan (subject to satisfaction of any other eligibility requirements) on the presumption that he or she will be scheduled to work at least 32 hours per week. Following the employee's completion of 12 full months of employment, his or her continuing eligibility for medical coverage for a subsequent plan year (the "Stability Period") will be based on the employee's average number of hours of service for the specified 12-month period (the "Measurement Period") prior to the start of the Stability Period.

Employees who average at least 130 hours of service per month (i.e., the monthly equivalent of 30 hours of service per week) during the Measurement Period will be eligible for medical coverage for the following Stability Period; provided they are not members of the excluded class of ineligible individuals. The Plan may use the weekly rule under the monthly measurement method (discussed below) will have to divide the year into four- and five-week periods—which act as proxies for months—and employees averaging at least 30 hours per week during those periods will be treated as full-time employees

The term "hour of service" refers to each hour for which you are paid, or entitled to payment, for the performance of duties for the University; and each hour for which you are paid, or entitled to payment, by the University for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. However, an hour of service does not include any hours after you terminate employment, or hours paid solely to comply with a workers' compensation law. With respect to short- or long-term disability leave, an hour of service is credited only for periods during which you retain employee status and receive disability benefits directly or indirectly funded by the University.

If you are an hourly employee, your actual hours of service will be calculated based on the records of hours worked and non-worked hours for which payment is made or due (e.g., vacation, holiday, illness, incapacity, etc.). For salaried employees, the University will calculate hours of service using one of the following three methods: (1) actual counting of hours of service; (2) using a days-worked equivalency (i.e., eight hours of service for each day for which the employee is entitled to pay for worked or non-worked time); or (3) using a weeks-worked equivalency (i.e., 40 hours of service per week for each week for which the employee is entitled to pay for worked or non-worked time).

In the case of adjunct faculty members, the University credits 2.25 hours of service for each hour of teaching or classroom time (i.e., an additional 1.25 hours is credited for activities such as class preparation and grading). In addition, the University credits one hour of service for each additional hour you spend on other non-classroom duties (e.g., required office hours or required attendance at faculty meetings).

## **Eligible Retirees**

A full-time employee of the University's St. Louis campus is eligible to participate in the medical component of the Plan as a retiree if the employee is age 60 years or older and has completed at least seven qualified continuous years of service as a full-time employee with the University at the time of his or her retirement.

The medical coverage options offered under the Plan at the time of retirement may differ from the options that were available to the retiree as an active employee.

## **Eligible Dependents**

You may also elect to enroll your eligible dependents in certain benefits under the Plan; provided you elect coverage for yourself. For this purpose, eligible dependents generally are limited to:

- Your legal spouse, as determined under applicable law. However, in order to be an eligible dependent for medical coverage under the Plan, a spouse also must satisfy one of the following criteria:
  - Is not employed or is self-employed;
  - Is not eligible for medical coverage through his or her employer (other than as a retiree or COBRA participant); or
  - Is offered coverage providing preventive care, major medical and prescription drug benefits but the employer contributes less than 50% of the premium for employee-only coverage.
- Your or your spouse's child who is under age 26.

The term "child" means a natural child, stepchild, legally adopted child or a child placed with you for adoption pursuant to a legal proceeding or a child for whom you or your spouse are the legal guardian pursuant to a judgment, decree or other order of a court of competent jurisdiction. With respect to certain benefits (e.g., medical and dental), continued eligibility may be extended beyond the prescribed limiting age of 26 for an unmarried child who is dependent on you or your spouse for support due to a physical or mental impairment.

As a retiree, your eligible dependents are limited to those family members who were enrolled in medical coverage under the Plan at the time of your retirement from the University, except as otherwise required with respect to a special enrollment right involving the acquisition of a new dependent.

***IMPORTANT NOTE:** Consult the Benefit Booklets for more information on the specific eligibility rules (e.g., age, residency and/or financial support) and exclusions.*

The Plan Administrator has the sole and absolute discretion and authority to verify the initial and continuing eligibility for participation and benefits under the Plan of any person, including any child, spouse, or dependent of an employee or retiree, by requesting proof of such eligibility including, as applicable and without limitation, tax returns, marriage certificates, birth certificates, proof of residence or other documentation deemed appropriate by the Plan Administrator. The Plan Administrator has the sole and absolute discretion to refuse enrollment or continuing participation in a Plan to any individual who refuses or otherwise fails to provide such proof of eligibility.

## **Qualified Medical Child Support Order**

If required by a qualified medical child support order (“QMCSO”), you and/or an eligible dependent child will be enrolled for medical, dental and/or vision coverage(s) in accordance with the terms of the order. Upon written request to the Plan Administrator, you may obtain, without charge, a copy of the Plan’s procedures governing QMCSO determinations.

## ***ENROLLMENT***

### **Initial Enrollment Period**

If you are eligible to participate in any elective benefit available under a Plan as an employee, the Plan Administrator will send you information on how to enroll. You will have 31 days (or such other period specified in the applicable Benefit Booklet) after the date you first become eligible to enroll in any elective benefits in accordance with the procedures established by the University. If you fail to enroll within your 31-day initial enrollment period, you will be treated as having declined coverage for yourself and your dependents under the elective benefits for the remainder of the Plan Year. You may not enroll or otherwise change any coverage elections until the next annual Open Enrollment period, unless you become entitled to a special enrollment right or experience a qualifying event permitting a mid-year change.

Generally, non-elective benefits that do not require any employee contributions automatically are made available to you under the Plan upon your satisfaction of the applicable eligibility requirements and no enrollment elections are required. Long-term disability coverage is not considered a fully non-elective benefit since certain employees are required to contribute towards their coverage. The University automatically enrolls eligible employees in long-term disability coverage but such employees may make an election to disenroll in coverage at any time.

If you are an eligible retiree, the Plan Administrator will send you information on how to enroll (or continue participation) in medical coverage under the Plan. You will have 60 days after you retire from the University to enroll in medical coverage as a retiree in accordance with the procedures established by the University. You must reenroll in medical coverage as a retiree even if you are currently participating in medical coverage under the Plan as an active employee. If you fail to enroll within your 60-day initial enrollment period, you will be treated as having permanently declined medical coverage under the Plan for yourself and your dependents. This is a one-time enrollment opportunity; you may not enroll in medical coverage at a later date (except under COBRA). Similarly, if you enroll in the retiree medical coverage during your initial enrollment period but subsequently drop coverage for yourself or any dependent for any reason, you may not reenroll in the medical coverage at a future date.

### **Open Enrollment Period**

Before the beginning of each Plan Year, the Plan Administrator will announce an Open Enrollment period and give you information on how to elect, change or revoke your elective benefit elections for the upcoming year. If you do not make new benefit elections during the annual Open Enrollment period in accordance with the procedures established by the Plan Administrator, you will be deemed to have elected to apply your current coverage elections for yourself and your dependents to the next Plan Year. However, if you wish to participate in the health flexible spending account, dependent care spending account or health savings account contributions for the next Plan Year, you must make an affirmative election for such benefits. Open Enrollment applies to eligible



employees as well as to covered retirees, long-term disability enrollees and COBRA participants; however, retirees and long-term disability enrollees may only switch to a different medical coverage option, if available. Long-term disability enrollees and retirees cannot enroll any dependents during Open Enrollment.

### **Special Enrollment Period**

If you or your eligible dependents were covered under another group health plan or had health insurance coverage at the time you declined coverage under one of the medical coverage options under the Plan and that other health coverage ends as a result of a loss of eligibility, cessation of employer contributions toward such other coverage or exhaustion of COBRA continuation coverage, you may in the future be able to enroll yourself or your dependents in one of the medical coverage options under the Plan, provided that you request enrollment within 31 days after your loss of other coverage (or the date employer contributions cease), unless otherwise provided in the applicable Benefit Booklet. This special enrollment right is available only to active employees and their eligible dependents.

If you are an active employee or a covered retiree and acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself (if you are an active employee who is not already enrolled) and your dependents in one of the medical coverage options, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption, unless otherwise provided in the applicable Benefit Booklet.

As an active employee, you or your eligible dependents who decline coverage under one of the medical coverage options because of existing health coverage under Medicaid or a state child health plan (commonly referred to as SCHIP), may be entitled to enroll in a medical coverage option under the Plan if coverage under the Medicaid or SCHIP program terminates due to a loss of eligibility for such coverage. You and your eligible dependents may also be entitled to a special enrollment right upon becoming eligible under Medicaid or SCHIP for premium assistance with respect to a medical coverage option under the Plan. You and/or your eligible dependent must request enrollment within 60 days after the Medicaid or SCHIP coverage ends or becoming eligible for the premium assistance (whichever is applicable), unless otherwise provided in the applicable Benefit Booklet.

All enrollment changes due to a special enrollment right are subject to the timely submission of requested documentation and approval of the Plan Administrator and/or insurer.

### ***PAYMENT OF PREMIUMS***

The University may pay none, all or a portion of the cost of coverage for you and/or your covered dependents. If you are an active employee, any premiums you are required to pay will be deducted from your regular paycheck. Subject to applicable IRS restrictions (such as in the case of any elected spousal or dependent life insurance coverage), the deductions will be made on a pre-tax basis, effective with the first pay period beginning on or after the effective date of your participation in such coverage(s).

The applicable premium amounts will be provided to you with your enrollment information. For retirees and any current and former employees who are not receiving a regular paycheck from the

University (e.g., unpaid leaves of absences or long-term disability enrollees) payment information will also be provided to you.

Note that if the employer-paid group term life coverage provided to you under the Plan exceeds \$50,000, the value of the excess coverage will be imputed as taxable income to you. With respect to long-term disability benefits, if you and the University both pay a portion of the applicable premium, the benefit amount you receive that is attributable to the portion of coverage paid by the University or is paid by you on a pre-tax basis is includible in your income. If you pay the entire cost of your coverage on an after-tax basis, any long-term disability benefit payable to you under the Plan is not taxable.

## ***PARTICIPATION***

### **When Coverage Begins**

If you elect coverage during your initial enrollment period, your coverage will be effective on your date of hire (or initial eligibility date, if later) unless otherwise provided in the Benefit Booklet. However, if you are a member of a union, your coverage commencement date will be governed by the terms of your collective bargaining agreement.

If you enroll during Open Enrollment, coverage begins on the first day of the next Plan Year, unless otherwise required by your collective bargaining agreement.

If you request any coverage under the Plan for yourself and/or any dependents on account of a qualifying event permitting a mid-year change (see below) or during a special enrollment period, such coverage will commence on the date of the qualifying event or special enrollment event, provided you timely provide any required documentation.

However, if your qualifying event or special enrollment request involves your acquisition of a newborn or newly placed or adopted child, coverage will start on the date of the child's birth or the date the child is adopted or placed with you for adoption, provided you timely request enrollment and provide any required documentation.

***IMPORTANT NOTE:** You should also consult each Benefit Booklet as it may include additional participation criteria or different participation commencement dates (e.g., active service requirement). With respect to any actively at work requirement that affects the timing of your coverage commencement date under a health plan option, you will be deemed to be actively at work if your absence is due to a health factor.*

Participation in the Plan and commencement of coverage under any Benefit Component(s) are subject to your timely enrollment and submission of any documentation and/or information requested by the Plan Administrator for purposes of confirming your eligibility (or that of your dependents) to participate in a Plan or in order for a Plan to comply with applicable law.

### **Leaves of Absence**

Your medical coverage under the Plan during an approved leave of absence will continue up until the later of: (1) the last day of the Stability Period for which you qualified as eligible for medical coverage due to your hours of service during the associated Measurement Period; or (2) the date six months after the commencement of your approved leave in accordance with your coverage election

in effect for the Plan Year, subject to any permissible mid-year election or annual enrollment changes and restrictions in the applicable Benefit Booklet. Unless otherwise provided in a Benefit Booklet, your other Plan benefits continue during the approved leave of absence for up to six months (or twelve months for a faculty member on an approved medical leave) in accordance with your coverage elections for the applicable Plan Year, subject to any permissible mid-year election or annual enrollment changes.

If your leave is paid, you will continue to pay your contribution in the same manner as before the paid leave. If you are on unpaid leave, you must pay your contributions on an after-tax basis as such amounts become due to continue your coverage.

Also review the sections on the Family and Medical Leave Act (FMLA) and the Uniformed Services Employment and Reemployment Rights Act (“USERRA”).

### **Sabbaticals**

Your participation in the Plan during an approved sabbatical continues for up to twelve months (or for medical coverage, the end of the applicable Stability Period, if later) in accordance with your coverage elections, subject to any permissible election changes and restrictions in the applicable Benefit Booklet. You must pay any required contributions on an after-tax basis as such amounts become due to continue your coverage.

### **Long Term Disability Enrollees**

If you are approved for long-term disability benefits under the Plan, you may continue your medical coverage under the Plan at the active employee rate for up to 30 months following your termination of employment; provided you remain disabled and pay your required contributions when due. To the extent you remain disabled after the expiration of the 30-month period, you may continue your medical coverage under the Plan up until you attain age 65 by paying the full cost of such coverage. However, for long-term disability benefits commencing on or after July 1, 2021, medical coverage following your termination of employment continues at the active employee rate only until the earlier of (1) 30 months or (2) your attainment of age 65.

***IMPORTANT NOTE:** You should also consult each Benefit Booklet as it may include special rules or additional opportunities for continuation of coverage during periods of disability, a temporary leave of absence, layoff or sabbatical.*

### **Rehires**

If you terminate employment and are rehired by the University in the same Plan Year and within 30 days of your termination date, your prior coverage elections under the Plan will resume for the remainder of the Plan Year and benefits will become effective on your rehire date; provided you continue to be eligible to participate in the respective Benefit Component(s). You cannot make new benefit elections, except as otherwise provided under the rules allowing for mid-year election changes. In contrast, if you are rehired in a different Plan Year or more than 30 days after your termination date, you may make new benefit elections; provided you are eligible to participate in the Plan.

If you participate in the Plan as a retiree and subsequently are rehired by the University, your retiree medical coverage under the Plan will automatically convert to active employee coverage; provided

you qualify as an eligible employee. If you are rehired but you are not eligible to participate in the Plan in your new position, your retiree medical coverage under the Plan will remain in effect unless you subsequently become eligible for medical coverage under the Plan as an active employee.

## ***CHANGING YOUR COVERAGE MID-YEAR***

### **Change in Status Events**

Your enrollment elections and coverage levels for any benefit(s) as an employee generally are irrevocable and remain in place for the entire Plan Year. However, you may revoke or change your elections within a Plan Year if you experience any of the following change in status events:

- An event that changes your legal marital status, including marriage, death of spouse, divorce, legal separation, or annulment.
- An event that changes the number of your dependents, including birth, adoption, placement for adoption, or death.
- Changes in your, your spouse's or your dependent's place of residence that result in a gain or loss of eligibility for coverage.
- A change in your, your spouse's, or your dependent's employment status, including a termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, or a change in worksite that results in a gain or loss of eligibility for coverage.
- An event that causes your dependent to satisfy or cease to satisfy the requirements for dependent coverage as provided in the Plan.
- An order by a court or state child support agency resulting from a divorce, legal separation, annulment, or change in custody, requiring you to provide health coverage for your child(ren).

### **Other Coverage Changes**

You also may make an election change with respect to a Benefit Component in response to certain plan or coverage changes. However, these rules do not apply to health flexible spending accounts.

- **Change Under Other Employer Plan.** You may make a change in your benefit election that is on account of and corresponds with a change made under another employer plan (including a plan of your spouse's or dependent's employer).
- **Significant Cost Change.** If the employee contribution for a benefit option significantly increases or significantly decreases during the Plan Year, you can make a corresponding change in election to enroll in the benefit with the decreased cost, or, in the case of an increase in cost, revoke your election for that coverage and enroll in another benefit option providing similar coverage or drop coverage if no other benefit option providing similar coverage is available.

- **Significant Curtailment of Coverage.** If a significant curtailment of coverage under a benefit option occurs during a Plan Year that is not a loss of coverage (e.g., a significant increase in the deductible, the copay, or the out-of-pocket maximum under the medical plan), you may revoke your election for that coverage and enroll in another benefit option providing similar coverage. Coverage is considered significantly curtailed only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally. If the curtailment results in a loss of coverage, you may drop such coverage if no similar benefit option is available.
- **Addition or Significant Improvement of Benefit Option.** If the Plan adds a new benefit or other coverage option, or if coverage under an existing benefit option or other coverage option is significantly improved during the Plan Year, you may revoke your existing election (including a waiver of coverage) and enroll for coverage under the new or improved benefit option.

In addition, you may be eligible to revoke your election for medical coverage under the Plan on a prospective basis under the following circumstances:

- You enroll in a qualified health plan through a marketplace either during a special enrollment period or annual open enrollment period and such coverage is effective no later than the day immediately following the last day of medical coverage under the Plan.
- You experience a reduction in hours of service (even if you do not lose eligibility for the medical coverage under the Plan) and you enroll yourself and any covered dependents in new medical coverage that is effective no later than the first day of the second month following the month of the revocation of your medical coverage under the Plan.

### **Making an Election Change**

Unless otherwise provided by the Plan Administrator, you must submit your election change (and any required documentation) to the Plan Administrator within 31 days of the occurrence of the event triggering your right to make a mid-year election change. For all mid-year election changes, the Plan Administrator has the discretionary authority to make a determination as to whether an event has occurred permitting a change during the coverage period and whether the requested change is on account of and consistent with the rules and regulations of the Internal Revenue Service.

Covered retirees are not subject to the restrictions on mid-year election changes and may elect to terminate coverage for themselves or their covered dependents at any time. However, once medical coverage is terminated it cannot be reinstated at a later date.

### ***WHEN COVERAGE ENDS***

Unless otherwise provided in a Benefit Booklet, coverage under the Plan (or a Benefit Component under the Plan) will end on the earliest of the following:

- The date you (or in the case of dependent coverage, your dependent) cease to satisfy the eligibility requirements under the Plan (or applicable Benefit Component), except that any

medical, dental or vision coverage terminates on the last day of the month in which eligibility ends;

- The date you fail to timely pay the required premiums or contributions, if any, toward the cost of the applicable Plan coverage;
- The date you elect to terminate such coverage, provided such an election is permissible under the Plan (or applicable Benefit Component);
- The date the Plan (or applicable Benefit Component) is amended to eliminate such coverage or eligibility for you and/or your dependents;
- The date the Plan (or applicable Benefit Component) is terminated.

Coverage for a dependent may also end if you fail to timely submit information and/or documents requested by the Plan Administrator regarding your dependent's eligibility status.

When health coverage under the Plan would otherwise end, you and/or your dependents may be able to elect continuation coverage under COBRA or similar laws. See the "Continuation of Coverage" section of this SPD for more information regarding COBRA.

***IMPORTANT NOTE:** You should also consult each Benefit Booklet as it may include additional termination events (e.g., active duty military service) or allow for conversion to an individual policy upon a loss of coverage under the Plan.*

### ***ADDITIONAL RULES FOR GROUP HEALTH PLAN COMPONENTS***

The following federal laws are applicable only with respect to any Benefit Component under the Plan that constitutes a group health plan:

#### **Family and Medical Leave Act (FMLA)**

If you take a leave of absence from work pursuant to the Family and Medical Leave Act of 1993 ("FMLA"), your health coverage under the Plan will continue under the same terms and conditions that would have applied had you continued working, unless you elect otherwise. If you continue coverage during your FMLA leave, your method of payment of required contributions will depend on whether you are on paid or unpaid FMLA leave.

If your leave is paid FMLA leave, you will continue to pay your contribution in the same manner as before the paid leave (i.e., deducted from your regular pay). If you are on unpaid FMLA leave, you will pay your contributions on an after-tax basis as such amounts become due during your leave.

#### *Coordination with COBRA*

If your health coverage ends due to your failure to return to active work with the University after your FMLA leave has expired or if you give the University notice of your intent not to return to active work before the end of your FMLA leave, your coverage may be continued under COBRA.

Among other things, this means that you generally will be responsible for payment of the entire cost of coverage and an administrative fee during the period that benefits are continued under COBRA. Your period of coverage during FMLA leave will not be counted toward the maximum number of months of coverage you are permitted under COBRA.

#### *Failure to Pay*

Unless otherwise provided in a Benefit Booklet, your coverage during FMLA leave will cease if your payment for any required contribution is more than 30 days late. However, before your coverage is terminated, you will receive a written notice that you are delinquent on your contribution, and you will have at least 15 days from the date of the notice to make the required payment. If you do not make the required contribution by the date specified in the notice, your coverage may be terminated retroactively to the date the unpaid contribution was due. If the University is not permitted to terminate your coverage retroactively, coverage will be terminated at the end of the 30-day grace period.

#### *Reinstatement of Coverage*

Unless otherwise provided in a Benefit Booklet, if your coverage was terminated during your FMLA leave, either because you failed to pay your portion of the contribution or because you elected not to continue coverage, your coverage may be reinstated on the date you return to active employment if you (i) return to active employment immediately upon expiration of your FMLA leave, (ii) re-enroll for coverage within 30 days of your return to active employment, and (iii) make the required contribution. You will not be required to satisfy any eligibility waiting period when you re-enroll.

### **Uniformed Services Employment and Reemployment Rights Act (USERRA)**

If you have coverage under a group health plan option and become absent from employment with the University due to services in the uniformed services, including active or reserved duty (whether voluntary or involuntary) you may continue such coverage for up to 24 months. If the duration of your military service is up to 31 days, the cost of continuing coverage will not exceed the amount you would normally pay for such coverage. If your period of military service is greater than 31 days, you will be charged the COBRA rate. Any continuation coverage available under USERRA will run concurrently with any COBRA coverage.

If your group health coverage terminates due to the military leave and you elect to have such coverage reinstated upon reemployment, no exclusions or waiting periods can be imposed. The only exception to USERRA's prohibition of exclusions is for an illness or injury determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during performance of service in the uniformed services. If you return to active employment during the same Plan Year in which you left, eligible charges you had accumulated towards satisfying deductibles and out-of-pocket maximums will be taken into account in determining your benefits for that Plan Year.

### **Consolidated Omnibus Budget Reconciliation Act ("COBRA")**

COBRA continuation coverage is a temporary extension of group health plan coverage. This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may

also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

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

COBRA continuation coverage is a continuation of group health coverage when it would otherwise end because of a "COBRA qualifying event." After a COBRA qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the group health plan is lost because of the COBRA qualifying event.

#### *COBRA Qualifying Events*

As an employee, you will become a qualified beneficiary if you lose your group health coverage under a Plan because of the following COBRA qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

NOTE: With respect to medical coverage, a long-term disability enrollee becomes eligible for COBRA continuation coverage only if the medical coverage ends before the expiration of the maximum 18-month COBRA continuation period.

As the spouse of an employee, you will become a qualified beneficiary if you lose your group health coverage under a Plan because of the following COBRA qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.



If an employee drops coverage for a spouse in anticipation of a divorce, the spouse is still entitled to 36 months of COBRA coverage but measured from the date of the divorce and not from the date of the loss of coverage.

Your dependent children will become qualified beneficiaries if they lose group health coverage under a Plan because of the following COBRA qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a COBRA qualifying event has occurred.

#### *Notice Requirements*

Your employer will notify the Plan Administrator of the following COBRA qualifying events:

- The end of your employment or reduction of hours of employment;
- Your death
- You becoming entitled to Medicare benefits (under Part A, Part B, or both).

However, you are responsible for notifying the Plan Administrator in writing of a divorce, legal separation, or a dependent's loss of eligibility status within 60 days after the later of the date the COBRA qualifying event occurs or the date coverage ends due to the event. If you fail to provide timely notice in accordance with the Notice Procedures, COBRA coverage will not be available.

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

#### *Children Born to You During COBRA Continuation Coverage*

If you acquire a new dependent by birth, adoption, or placement for adoption during your COBRA continuation period, the child may be enrolled immediately for COBRA continuation coverage and the child has the same rights during the open enrollment period as any other person in the family who has COBRA continuation coverage. The maximum COBRA continuation coverage period for

the child is the same as the maximum period that applies to other members of the family. It is not measured from the date of the birth, adoption, or placement for adoption. You must notify the COBRA Administrator within 30 days of the birth.

#### *Maximum COBRA Continuation Period*

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the termination of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

If the qualifying event is the employee's termination of employment or reduction of hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. However, there are two ways in which this 18-month period of COBRA continuation coverage can be extended.

#### *Disability extension of 18-month period of COBRA continuation coverage.*

If you or anyone in your family covered under the Plan is determined by the Social Security Administration ("SSA") to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

To obtain the 11-month extension, you or a covered family member notice must notify the COBRA Administrator of the SSA's disability determination before the end of the first 18-month period of COBRA continuation coverage and within 60 days of the later of: (1) the date of the SSA determination; (2) the date of the qualifying event; or (3) the date you would otherwise lose coverage under the Plan. Notice must be sent in writing, postmarked within the above timeframes, to the COBRA Administrator however, the COBRA Administrator may, in its discretion, accept oral notice if such oral notice is received within the above timeframes and complete written notice follows within one week of such oral notice.

If the SSA determines that you (or a covered family member) are no longer qualified for Social Security disability benefits, you or a covered family member must notify the COBRA Administrator in writing within 30 days of the date of the SSA's determination.

#### *Second Qualifying COBRA Event Extension*

Your spouse and dependent children can get up to 18 additional months of COBRA continuation coverage (for a maximum of 36 months) if your family experiences another COBRA qualifying

event during the 18 months of COBRA continuation coverage and the Plan is properly notified about the second COBRA qualifying event. This extension is also available to the spouse and any dependent children getting COBRA continuation coverage due to the employee's death, entitlement to Medicare benefits (under Part A, Part B, or both) or divorce or legal separation; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second COBRA qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first COBRA qualifying event not occurred. In all of these cases, you must notify the COBRA Administrator in writing of the second qualifying event within 60 days of the second qualifying event.

#### *Notice Procedures*

Any notice to the Plan Administrator must be mailed or delivered to the following address:

Saint Louis University  
3545 Lindell Blvd.  
Wool Center  
St. Louis, MO 63103

Any notice to the COBRA Administrator, must be mailed or delivered to the address listed on your most recent COBRA notice.

If mailed or sent by a delivery service, your notice must be postmarked no later than the last day of the required notice period. If hand delivered, your notice must be physically received no later than the last day of the required notice period. Any notice you provide must state the name of the Plan, the qualifying event and the date of its occurrence, the name and address of the employee covered under the Plan(s), and the name(s) and address(es) of the qualified beneficiary(ies).

#### *Other Coverage Options*

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

#### *Additional Information*

If you have questions concerning your group health plan or your COBRA continuation coverage rights contact the Plan Administrator. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

### ***COORDINATION OF BENEFITS***

If you or your enrolled dependents are covered by any other health plan (for example, if your child also has medical coverage through your spouse's plan), benefits from the Plan and the other plan will be coordinated. This means the benefits you receive from group health coverage under the Plan, when combined with the benefits from all other group plans, will not add up to more than the total expenses payable under the Plan. The Plan will also not duplicate any payment made by another plan.

If you have coordinated coverage, one of the plans will be designated as the primary plan and the other as the secondary plan. The primary plan pays benefits under its provisions first. Then the secondary plan pays for remaining expenses covered under its provisions.

Unless otherwise provided in the applicable Benefit Booklet, the following coordination of benefits rules apply:

- If a plan does not have a coordination of benefits provision, that plan will be the primary payer.
- The plan that covers the individual as an employee is the primary payer and pays before a plan that covers the individual as a dependent.
- The plan that covers the individual as an active employee is the primary payer and pays before a plan that covers the individual as an inactive employee.
- If you and your spouse both cover your children, rules for determining which plan is primary are determined by:
  - If you are not separated or divorced, the plan of the parent born earlier in the year is primary. This is known as the birthday rule. If both parents have the same birthday, the plan which has covered the parent longer is primary.
  - If you are divorced or separated, the plans pay benefits in this order: (1) the plan of the parent with custody, (2) the plan of the step-parent married to the parent with custody, (3) the plan of the parent without custody, and (4) the plan of the step-parent married to the parent without custody. However, if a divorce decree states that one of the parents is responsible for the health care of that child, then the plan of that parent is primary to the plans in (1) to (4).
- If none of the above rules determine the order of benefits, then the plan that has covered the person for the longer period of time will be primary. If you receive duplicate payments under the Plan and another health benefit plan, the Plan will collect that duplicate payment from you.

### **Coordination of Benefits With Medicare**

Federal law dictates when Medicare will pay primary and when Medicare will be a secondary payer. Generally, for active employees and their covered spouses who are entitled to age- or disability-based Medicare, the Plan pays primary to Medicare. For individuals who qualify for age-based Medicare and do not have Plan coverage by virtue of their own or a family member's current

employment status with the University (e.g., retirees and COBRA participants), the Plan pays secondary (this may be case even if the individual is not enrolled in Medicare).

A covered employee who is not actively working still is considered to maintain current employment status during the first six months of receiving disability benefits from the University. Medicare is the secondary payer for the first 30 months of an individual's ESRD-based Medicare eligibility or entitlement, regardless of the individual's employment status or source of coverage. However, Medicare remains primary for an individual who was entitled to Medicare due to age or disability on a primary basis at the time he or she becomes eligible for ESRD-based Medicare.

## **Medicaid**

Payment of benefits will be made in accordance with any assignment of rights made by or on behalf of you or an eligible dependent under the Plan as required by Medicaid. In addition, in enrolling an individual or eligible dependent or in determining or making any payment for benefits, the fact that an individual is eligible for or is provided benefits through Medicaid will not be taken into account.

## ***CLAIMS, APPEALS AND EXTERNAL REVIEWS***

The procedures and timing governing claims and appeals for benefits are generally described in the applicable Benefit Booklet. You, your representative or your provider must submit claims to the appropriate insurer or claims administrator. Refer to the Benefit Booklet for the applicable contact information.

***IMPORTANT NOTE:** You should also consult each Benefit Booklet for specific deadlines for submitting a claim and/or appeal. Failure to act within the applicable deadline generally will result in the automatic denial of your claim or appeal.*

For purposes of determining the amount of, and entitlement to, benefits under the self-funded component benefits under the Plan, the Plan Administrator is the named fiduciary. The Plan Administrator has full discretionary authority to consider all claims for self-funded benefits filed under the Plan and to determine eligibility, status, and rights of all individuals under the Plan and to construe any and all terms of the Plan. The Plan Administrator may delegate responsibility for claims administration to another person or third party, referred to as the Claims Administrator.

In contrast, insured benefits provided under one or more insurance policies issued to the Plan Sponsor are solely the responsibility of the applicable insurer. Accordingly, in the case of such benefits, the insurer identified in the Benefit Booklet has the discretionary authority to make all claims determinations and conduct all appeal procedures. Claims for such benefits under this Plan will be paid only if that entity decides, in its discretion, that such claims are covered.

For purposes of this Claim, Appeals and External Review Procedures section, the term "Claims Administrator" refers to the insurer or claims administrator identified in the Benefit Booklet as the responsible party for making benefit determinations. The term "Appeals Administrator" refers to the party responsible for handling appeals of adverse benefit determinations.

## **Claims Deadline**

Unless specifically provided otherwise in a Benefit Booklet or pursuant to applicable law, a claim for

benefits under this Plan (including any Component Benefit) must be made within one year after the date the expense was incurred that gives rise to the claim. It is the responsibility of the covered employee or dependent (or his or her designee) to make sure this requirement is met.

### **Limitations Period for Filing Suit**

Unless specifically provided otherwise under Benefit Booklet or pursuant to applicable law, any civil action or suit for a benefit under the Plan or any Component Benefit must be brought within one year after the date of a final decision on the claim under the Plan's applicable claims and internal appeals procedures.

### **Health Care Claims and Appeals**

In the absence of procedures and timing governing claims and appeals for health benefits in a Benefit Booklet, the procedures described in this section will apply.

#### *Claim Review*

The Claims Administrator will review your claim and will determine whether you satisfy all the requirements for benefits under the Plan. The determination regarding your claim will be made in accordance with the applicable procedures set forth below:

- *Post-Service Claims.* A post-service claim is any claim for a benefit that is after the medical care has been received. If your claim is denied, you will receive a written notice from the Claims Administrator within a reasonable period of time but not later than 30 days after receipt of the claim by the Claims Administrator. The 30-day period may be extended one time for up to an additional 15 days if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Claims Administrator and if the Claims Administrator notifies you, prior to the expiration of the initial 30-day period, of the reasons for the extension and the date by which a decision will be made. If the extension is needed because you have not submitted all the necessary information, the notice of extension will specifically describe the additional information that you must provide. You will have at least 45 days from your receipt of the notice to provide the additional required information. The extended claim determination period will be tolled on the date that the Claims Administrator sends such notice of missing information and resume on the date that you or your representative respond to the request. If you don't provide the required information within the 45-day period, your claim will be denied.
- *Pre-Service Claims.* A pre-service claim is any claim for a benefit that requires notification or precertification in advance of obtaining medical care. The Claims Administrator will notify you of its determination (whether adverse or not) regarding your claim within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Claims Administrator. The 15-day period may be extended one time for up to an additional 15 days if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Claims Administrator and notifies you, prior to the expiration of the initial 15-day period, of the reasons for the extension and the date by which a decision will be made. If you filed a claim but did not follow the claims procedures, the Claims Administrator will notify you of the failure and the proper

procedures as soon as possible but not later than 5 days after the claim was received. If an extension is needed because you have not submitted all the necessary information, the notice of extension will specifically describe the additional information that you must provide. You will be afforded at least 45 days from your receipt of the notice to provide the specified information. The extended claim determination period will be tolled on the date that the Claims Administrator sends such notice of missing information and resume on the date that you or your representative respond to the request. If you do not provide the required information within the 45-day period, your claim will be denied.

- *Urgent Care Claims.* An urgent care claim is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would cause you severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If your claim is considered to be an urgent care claim, the Claims Administrator will notify you of its determination (whether adverse or not) regarding your claim as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Claims Administrator. If you filed a claim but did not follow the claims procedures or did not provide all of the necessary information, the Claims Administrator will notify you of the failure and the proper procedures or specific additional information required as soon as possible but not later than 24 hours after the claim was received. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Administrator will notify you of its determination regarding your claim as soon as possible, but not later than 48 hours after the earlier of the time the required information is received by the Claims Administrator or the expiration of the specified period for providing additional information. If you do not provide the required information within the specified period, your claim will be denied.
- *Concurrent Care Claims.* If an on-going course of treatment involving urgent care was previously approved for a specific period of time or number of treatments, and you request that the course of treatment be extended beyond the previously approved period of time or number of treatments, the Claims Administrator will notify you of its determination (whether adverse or not) as soon as possible taking into account the medical exigencies but not later than 24 hours after the Claim Administrator's receipt of your request. Your request must be made at least 24 hours prior to the expiration of the approved course of treatment.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, any reduction or termination of the course of treatment (other than by plan amendment or termination) before the end of the previously approved period of time or number of treatments, will be considered a claim denial. The Claims Administrator will notify you of the claim denial at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

#### *If Your Claim is Denied*

If your claim is denied, the Claims Administrator will furnish you with written or electronic notice of

the denial. To the extent required by law, the notice will include the following:

- specific reason(s) for the denial;
- specific references to pertinent Plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to perfect your claim and an explanation of why the information is necessary;
- a description of available internal appeals procedures, including information about how to initiate an appeal and applicable time limits;
- a statement of your right to bring a civil action under ERISA § 502(a) following a denial on internal appeal;
- any specific internal rule, guideline, protocol, or similar criterion which was relied upon in denying the claim or a statement that it will be provided free of charge upon request;
- if the denial is based on a medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- if the denial relates to a claim involving urgent care, a description of the expedited review process applicable to such claims.

With respect to a claim for medical or prescription drug benefits, the notice of denial also will include the following:

- information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis and treatment codes (along with the corresponding meaning of such codes);
- a description of the Plan's standard, if any, used in denying the claim;
- a description of available internal appeals and external review procedures, including information on how to initiate an appeal; and
- disclosure of the availability of (and contact information for) any applicable ombudsman established under law to assist individuals with the internal claims and appeals and external review procedures.

### *How to Appeal a Claim*

If you are not satisfied with the action taken on your claim, you have the right to appeal the decision. You are not required to appeal the decision; however, you will not be entitled to bring a civil action under ERISA regarding your claim for benefits unless you have exhausted your internal appeal



rights.

If you wish to have an internal review of the denied claim, you must notify the Appeals Administrator in writing within 180 days of the date you receive notice of the denial (however, if the Plan requires a second level of appeal, the request for the next level of review must be submitted within 60 days after you receive notice of the initial denial on appeal). If an appeal involves urgent care, it may be made by telephone or fax. If you are appealing a decision to reduce or terminate an approved course of treatment, you must file an appeal before the proposed reduction or termination.

You may designate a representative to file an appeal on your behalf and to represent you in the appeal by providing the Appeals Administrator with a written designation of representation. However, in the case of an expedited review requested by a physician, such physician will be deemed to be your representative for purposes of such appeal without receipt of a signed designation.

Upon your request, you or your representative will be given reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits, free of charge. You or your representative may furnish the Appeals Administrator with a written statement of your position and with written materials (for example, records, documents, written comments and other information) in support of your position.

Your appeal will be reviewed and the decision made by the Appeals Administrator, who will be an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. The Appeals Administrator will make its decision solely on the basis of the written record, including documents and written materials submitted by you or your representative. The review will take into account all comments, documents, records and other information you submit relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Appeals Administrator will give no deference to the initial adverse benefit determination. In the case of a claim denied on the grounds of a medical judgment, the Appeals Administrator will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional who is consulted will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor a subordinate of that individual. Upon request, the Appeals Administrator will provide you with the name of the health care professional whose advice was obtained in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

In the case of an appeal of a claim for medical benefits, the following rules also will apply:

- You or your representative also will be permitted to review your claim file and to present evidence and testimony.
- You or your representative will be provided, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan in connection with your medical claim. Such evidence will be provided as soon as possible and sufficiently in advance so that you or your representative will have a reasonable opportunity to respond prior to the due date for notice of the final decision on appeal.

- Prior to issuing an adverse benefit determination on a medical claim based on a new or additional rationale, the Plan shall provide you or your representative, free of charge, with the rationale. Such rationale will be provided as soon as possible and sufficiently in advance to provide you or your representative a reasonable opportunity to respond prior to the due date for notice of the final decision on appeal.
- Additionally, no decisions involving hiring, compensation, termination, promotion, or related matters regarding any individual (*e.g.*, a claims adjudicator or medical expert) may be based on the likelihood that the individual will support the benefits denial.

#### *Timing of Decision on Appeal*

- *Post-Service Claim.* The Appeals Administrator will decide the appeal and notify you of its decision within a reasonable period but not later than 60 days (30 days of two levels of appeals is required) after receipt of your appeal.
- *Pre-Service Claim.* The Appeals Administrator will decide the appeal and notify you of its decision within a reasonable time appropriate to the medical circumstances but no later than 30 days (15 days of two levels of appeals is required) after receipt of your appeal.
- *Urgent Care Claim.* The Appeals Administrator will decide the appeal and notify you of its decision as soon as possible, taking into account the medical urgency, but no later than 72 hours after receipt of your appeal.
- *Concurrent Care Claim.* The Appeals Administrator will decide the appeal of a denied request to extend an on-going course of treatment in the appeal timeframe for urgent care, pre-service or post-service claims described above, as appropriate to the request. The Appeals Administrator will decide the appeal of a decision by the Plan to reduce or terminate an initially-approved course of treatment before the proposed reduction or termination takes place.

#### *Notice of Adverse Benefit Determination on Appeal*

If your appeal is denied, you will receive written or electronic notice of the denial. To the extent required by law, the notice will include:

- specific reason(s) for the denial;
- a specific references to pertinent Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the your claim for benefits;
- a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures;
- a statement of your right to bring a civil action under ERISA § 502(a);

- any specific internal rule, guideline, protocol, or similar criterion which was relied upon in denying the claim or a statement that it will be provided free of charge upon request;
- if the denial is based on a medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the case of an adverse determination of a medical claim on appeal, the notice also will include:

- sufficient information to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis and treatment codes (along with the corresponding meaning of such codes);
- a description of the Plan's standard, if any, used in denying the claim on review;
- a description of available internal appeals and external review procedures;
- the availability of (and contact information for) any applicable ombudsman established under law to assist individuals with the external review procedures; and
- in the case of a final internal adverse benefit determination, a discussion of the decision

### **External Review (Medical Only)**

After exhaustion of all appeal rights stated above, you may be eligible to request that the claim be reviewed under the Plan's external review process. An external review is available for any adverse benefit determination on medical claims involving: (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer or (2) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at the time). However, an external review is not available with respect to any denial, reduction, termination, or a failure to provide payment for a benefit relating to your failure to meet the Plan's eligibility requirements.

To assert this right to an independent external review, you (or your authorized representative) must request such review in writing within four (4) months after receipt of the final adverse benefit determination as described above. In the case of a self-funded group health plan, the request must be made to the Plan Administrator. Requests for an external review involving a fully-insured group health plan must be submitted to the entity specified in the applicable Benefit Booklet.

Generally, a claimant must exhaust the Plan's claims and appeals procedures in order to be eligible for the external review process. However, in some cases the Plan provides for an expedited external review if:

- The claimant receives an adverse benefit determination that involves a medical condition for which the time for completion of the Plan's internal claims and appeal procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and

the claimant has filed a request for an expedited internal review; or

- The claimant receives a final adverse benefit determination that involves a medical condition where the time for completion of a standard external review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

An external review under a fully-insured group health plan will be conducted in accordance with the applicable state external review process.

## **Disability Claims and Appeals**

In the absence of procedures and timing governing claims and appeals made under the Plan for benefits based on a determination of disability, the procedures described in this section will apply.

### *Claim Review*

The Claims Administrator will review your claim and will determine whether you satisfy all the requirements for benefits under the Plan. If your claim is denied, you will receive a written notice from the Claims Administrator within a reasonable period of time but not later than 45 days after receipt of the claim by the Claims Administrator. The 45-day period may be extended for up to an additional 30 days if the Claims Administrator determines that an extension is necessary due to matters beyond its control and notifies you, prior to the expiration of the initial 45-day period, of the reason(s) necessitating the extension and the date by which a decision is expected to be made. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that an additional extension is necessary due to matters beyond its control, the period may be extended for an additional 30 days if the Claims Administrator notifies you before the end of the initial 30-day extension period of the reason(s) for the extension and the date by which a decision is expected to be made. If the extension or extensions are needed because you have not submitted all the necessary information, the notice of extension will specifically describe the additional information that you must provide. You will have 45 days from your receipt of the notice to provide the additional required information. The extended claim determination period will be tolled on the date that the Claims Administrator sends such notice of missing information and resume on the date that you or your representative respond to the notice. If you don't provide the required information within the 45-day period, your claim will be denied.

### *If Your Claim is Denied*

If your claim is denied, the Claims Administrator will give you written or electronic notice of the denial. To the extent required by law, the notice will include the following:

- specific reasons for the denial;
- specific references to pertinent Plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to perfect your

claim and an explanation of why the information is necessary;

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following the views of: (1) the health care professionals treating you or the vocational professionals who evaluated you; (2) the medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination; and (3) a disability determination made by the Social Security Administration;
- an explanation of the appeals procedures and all applicable time limits and a statement of your right to bring a civil action under ERISA § 502(a) following a denial on appeal;
- the internal rules, guidelines, protocols, or other similar criteria that was relied upon in denying the claim, if any, or a statement that copies will be provided free of charge upon request (or if applicable, that no such rules, guidelines, protocols, standards or other similar criteria exist); and
- if the denial is based on a medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

### *How to Appeal a Claim*

If you are not satisfied with the action taken on your disability claim, you have the right to appeal the decision. You are not required to appeal the decision; however, you will not be entitled to bring a civil action under ERISA regarding your claim for benefits unless you have exhausted your appeal rights. You may designate a representative to file an appeal on your behalf and to represent you in the appeal by providing the Appeals Administrator with a written designation of representation.

If you wish to have a review of the denied claim, you must notify the Appeals Administrator in writing within 180 days of the date you receive notice of the denial (however, if the Plan requires a second level of appeal, the request for the next level of review must be submitted within 60 days after you receive notice of the initial denial on appeal).

Upon written request to the Claims Administrator, you or your representative have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits free of charge.

Your appeal will be reviewed and the decision made by the Appeals Administrator, who will be an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. The Appeals Administrator will make its decision solely on the basis of the written record, including documents and written materials submitted by you or your representative. The review will take into account all comments, documents, records and other information you submit relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Appeals Administrator will give no deference to the initial adverse benefit determination. In the case of a claim denied on the grounds of a medical judgment, the Appeals Administrator will consult

with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional who is consulted will be an individual who is neither an individual who as consulted in connection with the adverse benefit determination that is the subject of the appeal, nor a subordinate of that individual. Upon request, the Appeals Administrator will provide you with the name of the health care professional whose advice was obtained in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

The Plan will provide you or your authorized representative with any new or additional evidence considered, relied on, or generated by the Plan or decisionmaker in connection with the claim. The evidence will be provided to you as soon as possible and sufficiently in advance of the deadline by which the Appeals Administrator must provide you with notice of the Plan's decision on appeal to allow you to respond to the additional evidence. Before issuing an adverse benefit determination on appeal based on a new or additional rationale, the Plan or Appeals Administrator shall automatically provide the evidence or rationale to you (free of charge) and allow you a reasonable time to respond.

#### *Timing of Decision on Appeal*

The Appeals Administrator will decide the appeal and notify you of its decision within a reasonable period but not later than 45 days after receipt of your appeal, unless the Appeals Administrator determines that special circumstances require an extension of time for processing your appeal. If the Appeals Administrator determines that it needs additional time, before the end of the applicable 45-day period, it will notify you in writing before the end of the period and tell you the special circumstances requiring the extension and the date by which the Appeals Administrator expects to render a decision. In no event shall any extension exceed 45 days.

#### *Notice of Adverse Benefit Determination on Appeal*

If your appeal is denied, you will receive written or electronic notice of the denial. To the extent required by law, the notice will include:

- specific reason(s) for the denial;
- reference to the specific Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the your claim for benefits;
- a discussion of the decision, including an explanation of the basis for disagreeing with or not following (1) the views presented to the plan of health care professionals treating the claimant or vocational professionals who evaluated the claimant; (2) the views of medical or vocational experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the benefit determination; and (3) a SSA disability determination presented by the claimant to the Plan;
- a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures, and a statement of your right to bring a civil

action under ERISA § 502(a) following a benefit denial on appeal;

- a copy of any specific internal rule, guideline, protocol, or similar criterion which was relied upon in denying the claim or a statement that a copy will be provided free of charge upon request; and
- if the denial on appeal is based on a medical necessity or experiment treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to you medical circumstances, or statement that such explanation will be provided free of charge upon request.

## **ERISA Benefits Other Than Health or Disability**

In the absence of procedures and timing governing claims and appeals in a Benefit Booklet for benefits other than health or disability, the procedures described in this section will apply.

### *Claim Review*

The Claims Administrator will review your claim and will determine whether you satisfy all the requirements for benefits under the Plan. If your claim is denied, you will receive a written notice from the Claims Administrator within a reasonable period of time but not later than 90 days after receipt of the claim by the Claims Administrator. The 90-day period may be extended for up to an additional 90 days if the Claims Administrator determines that an extension is necessary due to matters beyond its control and notifies you, prior to the expiration of the original 90-day period, of the reason(s) for the extension and the date by which a decision is expected to be made. If the extension is needed because you have not submitted all the necessary information, the notice of extension will specifically describe the additional information that you must provide. You will have 45 days from your receipt of the notice to provide the additional required information. The extended claim determination period will be tolled on the date that the Claims Administrator sends such notice of missing information and resume on the date that you or your representative respond to the notice. If you do not provide the required information within the 45-day period, your claim will be denied.

### *If Your Claim is Denied*

If your claim is denied, the Claims Administrator will give you written or electronic notice of the denial. To the extent required by law, the notice will include the following:

- specific reasons for the denial;
- references to specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to perfect your claim and an explanation of why the information is necessary; and
- a description of the appeals procedures and all applicable time limits, including a statement of your right to bring a civil action under ERISA § 502(a) following a denial on appeal.

### *How to Appeal a Claim*

If you are not satisfied with the action taken on your claim, you have the right to appeal the decision. You are not required to appeal the decision; however, you will not be entitled to bring a civil action under ERISA regarding your claim for benefits unless you have exhausted your appeal rights.

If you wish to have a review of the denied claim, you must notify the Appeals Administrator in writing within 60 days of the date you receive notice of the denial (however, if the Plan requires a second level of appeal, the request for the next level of review must be submitted within 45 days after you receive notice of the initial denial on appeal).

Upon your request, you or your representative will be given reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits, free of charge. You or your representative may submit written comments, documents, records and other information relating to the claim for benefits. Your appeal will be reviewed and the decision made by someone not involved in the initial decision. The Appeals Administrator will make its decision solely on the basis of the written record, including documents and written materials submitted by you or your representative. The Appeals Administrator will give no deference to the initial benefit decision.

### *Timing of Decision on Appeal*

The Appeals Administrator will decide the appeal and notify you of its decision within a reasonable period but not later than 60 days after receipt of your appeal, unless the Appeals Administrator determines that special circumstances require an extension of time for processing your appeal. If the Appeals Administrator determines that it needs additional time, before the end of the applicable 60-day period, it will notify you in writing before the end of the period and tell you the special circumstances requiring the extension and the date by which the Appeals Administrator expects to render a decision. In no event will the extension exceed a period of 60 days from the end of the initial period.

### *Notice of Adverse Benefit Determination on Appeal*

If your appeal is denied, you will receive written or electronic notice of the denial. To the extent required by law the notice will include:

- specific reason(s) for the denial;
- reference to specific Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the your claim for benefits;
- a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- a statement of your right to bring a civil action under ERISA § 502(a) following a benefit denial on appeal.



## ***RECOVERY AND REIMBURSEMENT***

The Plan has the right to recover overpaid benefits and to seek subrogation or reimbursement in certain circumstances and with respect to certain Component Benefits. The applicable Benefits Booklets provide additional information about the Plan's recovery, subrogation, and reimbursement rights.

### **Refund of Overpayments**

Whenever a payment has been made under a Benefit Component (e.g., medical plan) in a total amount, at any time, in excess of the maximum amount payable under the Plan ("Overpayment"), you or any other covered dependent must refund to the Plan the applicable Overpayment and help the Plan recover the Overpayment from another person or organization. This includes any Overpayments resulting from retroactive awards received from any source, fraud, or any error made in processing your claim.

A Plan may, at its option, recover the Overpayment by reducing or offsetting against any future benefits payable to you, your covered dependent or beneficiary; stopping future benefit payments that would otherwise be due under the Plan (payments may resume once the Overpayment has been recovered); or demanding an immediate refund of the Overpayment from the covered person.

### **Misrepresentation**

If a participant or any other person makes any intentional misrepresentation or uses fraudulent means in applying for coverage under a Plan, making a change in his or her existing coverage election under a Plan, or filing a claim for benefits under a Plan, his or her coverage under such Plan may be subject to immediate termination, recoupment by the Plan of erroneously paid expenses based on the misrepresentation or fraud, and other remedies available to the Plan Administrator at law and in equity subject to and in accordance with applicable law.

## ***AMENDMENT OR TERMINATION OF THE PLAN***

The University, as the Plan sponsor, has the right to amend or terminate the Plan or any Component Benefit at any time without the consent of any employee, participant or beneficiary. No vested rights of any nature are provided by the Plan. Amendment or termination of the Plan or any Component Benefit shall be pursuant to a written instrument duly adopted by the University or any of its delegates, including but not limited to the Vice President of Human Resources, who is authorized to amend or terminate the Plan and to execute any insurance contracts with an insurer, including amendments to those contracts.

## ***YOUR RIGHTS UNDER ERISA***

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA").

ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest

annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of such coverage under the Plan as a result of a COBRA qualifying event. You or your dependents must pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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 benefit or exercising your rights under ERISA.

If your claim for a 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 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.

If you have any questions about the Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits

Security Administration, U.S. Department of Labor, 200 Constitution Avenue, 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.

### ***ERISA PLAN INFORMATION***

A Benefit Booklet may include information that appears to conflict with the ERISA information listed below for the Plan. In most cases, the information in the Benefit Booklet pertains to that respective component of the Plan and not to the Plan. In the event of a conflict between the ERISA information in a Benefit Booklet and the information listed below, this section governs.

#### **Plan Name and Number**

The Saint Louis University Welfare Benefit Plan (Plan Number 518)

#### **Type of Plan**

The Plan is an employee welfare benefit plan, within the meaning of ERISA Section 3(1), providing medical, prescription drug, dental, vision, long-term disability, basic and voluntary life and accidental death and dismemberment, business travel accident and voluntary accident benefits.

#### **Plan Year**

January 1 through December 31.

#### **Plan Sponsor and Employer Identification Number**

Saint Louis University  
3545 Lindell Blvd.  
Wool Center  
St. Louis, MO 63103

EIN: 43-0654872

#### **Plan Administrator**

Saint Louis University  
3545 Lindell Blvd.  
Wool Center  
St. Louis, MO 63103  
(314) 977-2595

As the Plan Administrator, the University has full discretionary authority to control and manage the overall operation and administration of the Plan, to construe and interpret the Plan, construe any ambiguous provisions of the Plan, make benefits decisions with respect to the self-insured benefits (except to the extent such authority has been delegated to a third-party), correct any defect, supply any omission and reconcile any inconsistency in such manner and to such extent as the Plan

Administrator in its sole discretion may determine. The Plan Administrator has engaged a third-party to administer claims for one or more of the self-funded benefits (e.g., medical plan). From time to time, the Plan Administrator may also delegate certain day-to-day administrative functions to the Human Resources Department.

With respect to benefits offered through an insurer, such benefits are fully operated, administered and financed by the insurer designated in the applicable Benefit Booklet and such insurer has complete discretionary authority to interpret its Benefit Booklet and group policy and to determine the proper payment of any claim.

Consult the applicable Benefit Booklets for the name and contact information of the third-party claims administrator or insurer.

### **Funding**

With the exception of medical and prescription drug coverages, the benefits provided under the Plan are fully insured pursuant to one or more group insurance policies. The insurance companies, not the University, are responsible for paying claims with respect to the insured Component Benefits. In contrast, the University is responsible for paying claims with respect to the self-funded Component Benefits from its general assets.

Contributions for any coverage under the Plan may be made solely by the University or by joint contributions from participating employees and the University. During the initial and subsequent Open Enrollment periods, the Plan Administrator will provide a schedule of the applicable premiums. Depending on the type of benefit, required employee contributions are made either on an after-tax basis or on a pre-tax basis through the University's cafeteria plan. No trust has been established for the payment of benefits under the Plan.

### **Agent for Service of Legal Process**

For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator at the above address. For disputes arising under a Benefit Component operated, administered or financed by an insurer, service of legal process must be made upon the insurer at the address listed in the applicable Benefit Booklet.