

SUFFOLK UNIVERSITY
HEALTH AND WELFARE BENEFITS PLAN
CONSOLIDATED PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION

Effective As of January 1, 2011

Amended As of January 1, 2015

The University reserves the right to amend this Plan at any time or from time-to-time without the consent of any Eligible Employee, Participant, dependent or beneficiary. Although the University expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan or any Plan Coverage Feature at any time without liability.

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INTRODUCTION

This document sets forth and describes the Suffolk University Health and Welfare Benefits Plan (the “Plan”) as amended January 1, 2013. Some of the terms in the Plan are capitalized. These terms are defined in the Glossary. The purpose of this Plan is to provide certain health and welfare benefits to you and your eligible dependents under one or more Welfare Benefit Contracts, as more fully described herein. Each health and welfare benefit offered under the Plan is referred to as a “Coverage Feature” of the Plan. The Coverage Features offered under the Plan are either “Non-Contributory Coverage Features,” which are provided to you at the University’s expense, or “Contributory Coverage Features,” which require you to pay all or part of the costs of the Coverage Feature.

The Non-Contributory Coverage Features are:

Life and Accidental Death & Dismemberment, Long Term Disability, Employee Assistance Program

The Contributory Coverage Features are:

Medical, Dental, Healthcare Flexible Spending Account, Voluntary Life

Each Coverage Feature has its own requirements for eligibility and enrollment. These requirements are set forth more fully in this Plan and in the Welfare Benefit Contracts, which are incorporated by reference into the Plan.

This document, together with the Welfare Benefit Contracts identified in Schedule A, constitute the written plan and the summary plan description as required by Section 102 of the Employee Retirement Income Security Act of 1974, as amended, (“ERISA”) and U.S. Department of Labor Regulation Sections 2520.102-2 and 2520.102-3 for the Plan. The provisions of the Welfare Benefit Contracts are incorporated by reference into this Plan document. If there is any conflict between this document and the Welfare Benefit Contracts, the Welfare Benefit Contracts will control.

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PART ONE: ELIGIBILITY AND ENROLLMENT

Eligibility

You are eligible to participate under the Plan if you are an Eligible Employee.

Eligible Dependents and Beneficiaries

The Welfare Benefit Contracts identify which Coverage Features may cover your Eligible Dependents or beneficiaries, as well as any requirements for their coverage. Upon request, you must provide proof of your dependents' eligibility for coverage.

Enrollment

If you are an Eligible Employee, you and your Eligible Dependents may enroll in a Coverage Feature once you meet the requirements for enrollment set forth in Schedule A. The Plan Administrator may establish enrollment procedures for each Coverage Feature in accordance with the Welfare Benefit Contracts for you and your Eligible Dependents under the Plan. The Plan Administrator may prescribe enrollment forms that must be completed by a prescribed deadline prior to commencement of coverage under the Plan. As a requirement of enrollment in one or more of the Coverage Features, the Plan Administrator may require that you and your Eligible Dependents provide certain personal information, including without limitation addresses and social security numbers.

Timing of Enrollment and Enrollment Changes

With respect to the following Coverage Features, once you have met the requirements for enrollment set forth on Schedule A, you will be automatically enrolled and will remain enrolled so long as you are an Eligible Employee:

Life and Accidental Death & Dismemberment, Long Term Disability, Employee Assistance Program

With respect to all other Coverage Features, your opportunities to enroll, as well as to change or cancel your enrollment, are limited to the following:

- You (and your Eligible Dependents) may enroll at the time you first meet the requirements for enrollment set forth on Schedule A;
- You (and your Eligible Dependents) may enroll, or change or cancel your enrollment, during an Annual Enrollment Period; or
- You (and your Eligible Dependents) may enroll, or change or cancel your enrollment, if you become eligible for a "special enrollment right" as described below.

Special Enrollment Rights

If you do not enroll yourself and your Eligible Dependents in any Coverage Feature that is a "group health plan" under Section 701 of ERISA after you first become eligible or during the Annual Enrollment Period, you may be able to enroll under the special enrollment rules under HIPAA that apply when an individual initially declines coverage and later wishes to elect it. Generally, special enrollment is

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available if (i) you or your Eligible Dependent initially declined coverage because you had other health care coverage and you (or your Eligible Dependent) have lost eligibility for that other health care coverage through no fault of your (or his or her) own; or (ii) since declining coverage initially, you have acquired a new dependent (through marriage or the birth or adoption or placement for adoption of a child) and wish to cover that person. In the former case, you must have given (in writing if a written statement was required at the time by the Plan Administrator and you were provided with a notice of that requirement and its consequences at that time) the alternative coverage as your reason for waiving coverage under the group health plan when you declined to participate. In either case, as long as you (and/or your Eligible Dependents) meet the necessary requirements under the group health plan (including eligibility requirements), you can enroll both yourself and all Eligible Dependents in the group health plan within **30 days** after you lose your alternative coverage or the date of your marriage or the birth, adoption, or placement for adoption of your child. Enrollment of your Eligible Dependents is generally conditioned upon your enrollment. Please contact the Plan Administrator for details about special enrollment.

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

- You or your dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under Title XXI of such Act and your (or your dependent's) coverage under such plan is terminated as a result of loss of eligibility for such coverage and you request coverage under the group health plan not later than **60 days** after the termination of such coverage; or
- You or your dependent become eligible for assistance, with respect to coverage under the group health plan under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if you request coverage under the group health plan not later than **60 days** after the date you or your dependent is determined to be eligible for such assistance.

Unless otherwise provided in the applicable Welfare Benefit Contract, this provision does not apply to a group health plan or group health insurance coverage in relation to its provision of Excepted Benefits. Please contact the Plan Administrator for details about special enrollment.

Qualified Medical Child Support Orders

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

- Establish reasonable procedures to determine whether medical child support orders are qualified medical child support orders as defined under Section 609 of ERISA;
- Promptly notify you and any alternate recipient (as defined in Section 609(a)(2)(C) of ERISA) of the receipt of any medical child support order, and the Group Medical Coverage Feature's

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procedures for determining whether medical child support orders are qualified medical child support orders; and

- Within a reasonable period of time after receipt of such order, the Plan Administrator will determine whether such order is a qualified medical child support order and will notify you and each alternate recipient of such determination.

A copy of the Plan's QMCSO procedures is available, without charge, upon request from the Plan Administrator.

Enrollment of Domestic Partners

If you have registered a domestic partnership with the Human Resources Department, your domestic partner (and the domestic partner's eligible children, if any) may be eligible for participation in some or all of the Coverage Features. The terms, limitations and tax consequences of domestic partner benefits are outlined in a separate Domestic Partner Benefits Policy/Affidavit, which you may obtain from the Human Resources Department.

Tax Implications

Medical and dental care are generally treated as non-taxable under federal tax law if they are provided to you, your spouse, your dependents, or your children who have not attained the age of 27 as of the end of a taxable year. Your "spouse" for this purpose includes any individual married to you in a state whose laws authorize your marriage (generally referred to as the "state of celebration"), in accordance with such state's laws, whether the spouse is of the opposite or the same sex as you. Your "children" and "dependents" are as defined under Section 105(b) of the Code. In addition, the University has established a "Cafeteria Plan" under Section 125 of the Code, so that you may have the ability to pay any employee portions of premiums for yourself and such individuals on a pre-tax basis.

If, however, a Coverage Feature makes medical, dental or vision care available for any individual who is not your spouse, child under age 27, or dependent (each as defined above), the value of the coverage provided to such individual is taxable to you for federal law purposes. Situations where these taxes may arise include domestic partnerships or civil unions (where the domestic partner or civil union partner is not your tax dependent), coverage of non-dependent grandchildren and ex-spouses, and coverage of a child beyond the end of the taxable year in which the child reaches age 26. This additional income, known as "imputed income," will be reported on your pay statement and Form W-2 Wage and Tax Statement for the year in which the coverage was provided. You will be required to pay taxes on this additional income, as required by the IRS and, if applicable, state tax authorities.

This document does not address every tax situation that may apply to every Plan Participant. For example, benefits provided under the Plan to certain individuals who are not common law employees of the University (such as partners in a partnership) may be subject to unique and complicated federal tax laws rules. In addition, this document does not address state and local tax treatment. For information on how applicable tax law may apply to your personal situation, please consult your tax adviser.

When Coverage Ends

Except in the case of COBRA rights described below, benefits for you and your Eligible Dependents under the Plan will terminate upon the earliest of:

- Except as required by applicable state law, the date you cease to be an Eligible Employee,

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- The date when you or your Eligible Dependent(s) no longer meet the eligibility requirements set forth on Schedule A or in an applicable Welfare Benefit Contract, provided that, effective for Plan Years beginning on or after October 9, 2009, if an Eligible Dependent is a Dependent Child on a Medically Necessary Leave of Absence, the coverage under a Group Medical Coverage Feature (other than an Excepted Benefit) shall not end until the earlier of (1) the date that is one year following the first day of the Medically Necessary Leave of Absence or (2) the date on which coverage under the Group Medical Coverage Feature would otherwise terminate under the terms of the Group Medical Coverage Feature.
- The time when you or your Eligible Dependent(s) **have exhausted the benefits** available under a Coverage Feature, as set forth in the applicable Welfare Benefit Contract,
- With respect to any Contributory Coverage Features, the last day for which necessary contributions are made,
- With respect to any insured Coverage Feature, the date when the group insurance policy applicable to the Coverage Feature terminates,
- With respect to any Coverage Feature, the date when the University amends the Plan to eliminate such Coverage Feature, or changes such Coverage Feature to eliminate eligibility for you and/or your Eligible Dependents, or
- The date the University terminates the Plan.

As noted below, the University reserves the right to change or eliminate benefits under the Plan and may amend or terminate the Plan at any time.

Certain Coverage Features may provide conversion rights. That is, when you cease to participate in the Coverage Feature, you have the right to convert your group coverage under the Coverage Feature into an individual policy. You will be responsible for all costs associated with such individual policy. See the Welfare Benefit Contracts for more details.

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PART TWO: BENEFITS AND CONTRIBUTIONS

General

Each Coverage Feature, including any amounts you must contribute towards a Contributory Coverage Feature, is more fully described (and subject to the limitations contained) in the Welfare Benefit Contracts and on Schedule A.

Benefit and Coverage Options

Each Contributory Coverage Feature may offer a selection of benefits from which you may choose. In addition, the Coverage Features may contain one or more coverage options including, without limitation:

- Eligible Employee only
- Eligible Employee plus spouse
- Eligible Employee plus child(ren)
- Eligible Employee plus family
- Certain Coverage Features may also offer coverage of grandchildren, domestic partners, former spouses, or other individuals, either pursuant to state law or per the Plan's design

The options and cost of your coverage may vary depending on which coverage or benefit option you select. Your options are more fully described (and subject to the limitations contained) in the Welfare Benefit Contracts and on Schedule A.

How Do I Pay for Contributory Coverage Features?

Your contributions for each Contributory Coverage Feature are set forth on Schedule A. The applicable Participating Employer will pay the remaining costs, if any, for each Contributory Coverage Feature.

The Plan Administrator **may require** that your contributions be made by payroll deduction. Your contributions will be used in funding the cost of the Plan benefits as soon as practicable after they have been received from you or withheld from your pay through payroll deduction.

Claims and Appeal Procedure

Any claim for benefits under the Plan and any subsequent appeal shall be filed in accordance with the provisions of the applicable Welfare Benefit Contract. Notice of the decision on such claim and any right to appeal such decision shall be provided by the Plan Administrator or, if delegated, by the insurance company or third-party administrator issuing the applicable Welfare Benefit Contract in accordance with the provisions of such contract, Section 503 of ERISA and any regulations thereunder in effect at the time the claim for benefits is made under the Plan.

With respect to any Coverage Feature, if the Welfare Benefit Contract does not contain a claims procedure, or if the Coverage Feature has no Welfare Benefit Contract, or if any claims procedure contained in a Welfare Benefit Contract fails to comply with DOL Regulation 2560.503-1, claims for

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benefits under the Plan and subsequent appeals shall be filed in accordance with the procedures set forth on Schedule C and Schedule D.

Special Benefit for Maternity and Infant Coverage

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

Special Benefit for Women's Health Coverage

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires group health plans, insurance issuers and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (iii) prostheses and physical complications at all stages of mastectomy, including lymphedemas. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other medical or surgical benefits provided under the Group Medical Coverage Feature. For answers to specific questions regarding WHCRA benefits, contact the Plan Administrator. Additional state laws may be applicable as more fully described in other materials detailing your medical benefits. Unless otherwise provided in the applicable Welfare Benefit Contract, this provision does not apply to a group health plan or group health insurance coverage in relation to its provision of Excepted Benefits.

Mental Health and Substance Use Disorder Parity

If any Group Medical Coverage Feature (1) provides both medical and surgical and mental health or substance use disorder benefits and (2) is not subject to an Increased Cost Exemption:

- The Group Medical Coverage Feature may not apply annual or lifetime limits for mental health or substance use disorders that are lower than those for medical and surgical benefits.
- The Group Medical Coverage Feature may not apply more restrictive financial requirements or treatment limitations to mental health or substance use disorder benefits in any classification than the predominant limitations applied to substantially all of the medical and surgical benefits in any classification.
- The criteria for medical necessity determinations made under any Group Medical Coverage Feature with respect to mental health or substance use disorder benefits shall be made available by the Plan Administrator (in accordance with the Wellstone Act) to any current or potential Participant upon request.
- The reason for any denial under the Plan of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any Participant shall, on request or as otherwise required under the Wellstone Act, be made available by

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the Plan Administrator to the Participant in accordance with the claims procedures applicable to the Group Medical Coverage Feature.

- The Plan shall be operated and construed in all respects in compliance with the MHPA and the Wellstone Act.

“Mental health benefits” and “substance use disorder benefits” mean benefits with respect to items or services for mental health conditions and substance use disorders, respectively, and shall be as defined in the Welfare Benefit Contract applicable to the Group Medical Coverage Feature, pursuant to applicable state and Federal law, and consistent with generally recognized standards of current medical practice.

Unless otherwise provided in the applicable Welfare Benefit Contract, this provision does not apply to a group health plan or group health insurance coverage in relation to its provision of Excepted Benefits.

Patient Protections

The HMO Group Medical Coverage Feature generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Group Medical Coverage Feature network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator at 617-573-8415.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Group Medical Coverage Feature or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator at 617-573-8415.

Unless otherwise provided in an applicable Welfare Benefit Contract, this provision does not apply to a group health plan or group health insurance coverage in relation to its provision of Excepted Benefits.

PART THREE: PLAN ADMINISTRATION

The Plan Administrator

The Plan Administrator has sole and absolute discretion and authority to (i) to interpret the terms of the Plan, (ii) to determine factual questions that arise in the course of administering the Plan, (iii) to adopt rules and regulations regarding the administration of the Plan, including enrollment procedures, (iv) to determine the conditions under which benefits become payable under the Plan, (v) to make determinations of eligibility under the Plan, (vi) to verify the initial and continuing eligibility for participation and benefits under the Plan of any person, including any child, spouse, domestic partner or dependent of an employee, by requesting proof of such eligibility including, as applicable and without limitation, tax returns, marriage certificates, birth certificates, proof of residence, proof of domestic partnership, or other documentation deemed appropriate by the Plan Administrator and (vii) to make any other determinations that the Plan Administrator believes are necessary and advisable for the administration of the Plan. Any interpretation or determination made by the Plan Administrator will be final, conclusive and binding on all parties. The Plan Administrator may delegate all or any portion of its authority to any person or entity.

Duties of the Plan Administrator

The Plan Administrator (i) administers the Plan in accordance with its terms, (ii) decides disputes which may arise relative to a Plan Participant's rights, (iii) keeps and maintains the Plan documents and all other records pertaining to the Plan, (iv) pays or arranges for the payment of claims, (v) establishes, communicates and implements procedures to determine whether a medical child support order is qualified under section 609 of ERISA, and (vi) performs all necessary reporting and disclosure as required by ERISA.

Plan Administrator Compensation

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

The Named Fiduciary

The Plan Administrator is a "named fiduciary" with respect to the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary will not be liable for any act or omission of such person unless either (i) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures or (ii) the named fiduciary has breached its fiduciary responsibility under section 405(a) of ERISA.

Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to Eligible Employees and their Eligible Dependents and beneficiaries, and defraying reasonable expenses of Plan administration. These duties must be carried out with the care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters,

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would use in a similar situation, and in accordance with Plan documents to the extent that they are consistent with ERISA.

Examination of Records

The Plan Administrator will generally make available to each Eligible Employee such of his or her records under the Plan as pertain to him or her for examination at reasonable times during normal business hours, but the Plan Administrator shall have no obligation to disclose any records or information which the Plan Administrator, in its sole discretion, determines to be of a privileged or confidential nature.

Reliance on Tables

In administering the Plan, the Plan Administrator is entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions or recommendations of accountants, counsel, actuaries, consultants or other experts employed or engaged by the Plan Administrator.

Indemnification of Administrator

The University agrees to indemnify and to defend to the fullest extent permitted by law any employee or Participating Employer serving as the Plan Administrator or as a member of a committee designated as Plan Administrator (including any employee or former employee who formerly served as Plan Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the University) occasioned by any act or omission to act in connection with the Plan undertaken within the scope of the employee's duties and responsibilities, if such act or omission is in good faith.

HIPAA Privacy Provisions

HIPAA requires group health plans to protect the confidentiality of your private health information. The Plan and the Company will not use or further disclose information that is protected by HIPAA ("Protected Health Information") except as necessary for treatment, payment, health plan operations and Plan administration, or as otherwise permitted or required by applicable law. In particular, the Plan will not, without authorization, use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company. In addition, the Plan requires all of its business associates (that is, service providers who help us administer the Plan) to also observe HIPAA's privacy rules.

Under HIPAA, you have certain rights with respect to your Protected Health Information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

To the extent required by applicable law, the Plan will maintain a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact the Plan Administrator. If you have questions about the privacy of your health information, or if you wish to file a complaint under HIPAA, you should contact the Company's privacy officer.

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Medical Loss Ratio Rebates

To the extent a rebate is paid to the University under the rules governing medical loss ratio with respect to the Group Medical Coverage Feature, the rebate will be apportioned between the University and Plan Participants in the discretion of the Plan Administrator in accordance with the principles set out in Department of Labor Technical Release 2011-04 (published December 2, 2011).

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PART FOUR: COBRA CONTINUATION COVERAGE

Introduction

If you are participating in any group health plan subject to COBRA, you may be entitled to COBRA continuation coverage, which is a temporary extension of coverage under the Plan, upon your termination of employment with a Participating Employer. Your spouse and other qualified beneficiaries may also be entitled to COBRA continuation coverage in specified circumstances. This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This section gives only an overview of your COBRA continuation coverage rights. For more information about your COBRA rights and obligations under the Plan and under federal law, you should ask the Plan Administrator.

COBRA continuation coverage for the group health plan is administered by Conexis 6191 North State Highway 161, Suite 400, Irving, Texas 75038 and is the party responsible for administering COBRA continuation coverage (the “COBRA Administrator”).

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

In addition to COBRA, there may be other coverage options available to you and your family. For example, you may be eligible to buy medical insurance coverage through the Marketplace. In the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of coverage under any group health plan subject to COBRA when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a 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 a group health plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Eligible Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an Eligible Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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- 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.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- 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."

A child who is born or placed for adoption with the covered employee during a period of COBRA continuation coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of Federal law, these qualified beneficiaries can be added to COBRA continuation coverage upon proper notification to the COBRA Administrator of the birth or adoption.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Eligible Employee, or the Eligible Employees becoming entitled to Medicare benefits (under Part A, Part B, or both), the University must notify the COBRA Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events. For all other qualifying events (divorce or legal separation of you and your spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You should send this notice, in writing, describing the qualifying event, to the Plan Administrator. If you do not provide timely notice, you may not be eligible for COBRA coverage.

COBRA Coverage and FMLA Leave. The taking of leave under FMLA does not constitute a qualifying event under COBRA. However, a qualifying event will generally occur if your FMLA leave ends and you do not return to work. Please contact the Plan Administrator for more information on your (and your spouse's or dependent children's) COBRA eligibility during and following your FMLA leave.

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How is COBRA Coverage Provided?

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Eligible Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Eligible Employee, the Eligible Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your 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 end of employment or reduction of the Eligible Employee's hours of employment, and the Eligible 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). When the qualifying event is the end of employment or reduction of the Eligible Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration ("SSA") to be disabled and you notify the COBRA Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability has 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 continuation coverage.

To obtain the 11-month extension, notice must be sent to the COBRA Administrator before the end of the first 18-month period of COBRA continuation coverage. Further, you (or a covered family member) must make sure that the COBRA Administrator is notified of the SSA's determination within 60 days of the later of: (a) the date of the SSA determination; (b) the date of the qualifying event; (c) the date you would otherwise lose coverage under the Plan; or (d) the date on which you are informed of both the responsibility to provide such notice and the Plan's procedures for providing such notice. Notice should 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, notice must be sent to the COBRA Administrator within 30 days of the later of: (a) the date of the SSA's determination or (b) the date on which you are informed of both the responsibility to provide such notice and the Plan's procedures for providing such notice. The disability extension coverage will terminate upon such determination. Notice should 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.

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the Eligible Employee or former Eligible Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you must make sure that the COBRA Administrator is notified of the second qualifying event within 60 days of the second qualifying event. You should give this notice prior to the qualifying event, or as soon as possible thereafter (but not more than 60 days after the qualifying event). Once the COBRA Administrator receives your notice, it must in turn notify you, your spouse, and children (individually or jointly) of their right to elect COBRA coverage. This notice must be sent to the COBRA Administrator.

Early Termination of COBRA Coverage

COBRA continuation coverage may terminate early if:

- The required premium payment is not paid when due;
- You and your spouse or dependent child(ren), if any, become covered under another group health plan after the date COBRA coverage is elected that does not contain any exclusion or limitation for any of your preexisting conditions;
- You, your spouse or dependent child(ren), if any, become entitled to Medicare benefits (under Part A, Part B, or both) after the date COBRA coverage is elected;
- All of the University's group health plans are terminated; or
- If coverage is extended to 29 months due to disability, a determination that the individual is no longer disabled. NOTE: Federal law requires that the individual inform the COBRA Administrator of any final determination that he or she is no longer disabled within 30 days of such a determination.

Continuation coverage under COBRA is provided subject to your eligibility. The COBRA Administrator reserves the right to terminate your COBRA coverage retroactively, subject to PPAC, if you are determined to be ineligible for coverage.

How can you elect continuation coverage?

Each qualified beneficiary has 60 days from either (1) the date coverage is lost under the Plan or (2) the date they are notified of their right to elect continuation coverage, whichever is later, to inform the COBRA Administrator that he or she wants to elect continuation coverage. Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the Eligible Employee and the Eligible Employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the election notice. Failure to do so will result in loss of the right to elect

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continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date. **There is no extension of the election period.**

If you, your spouse or dependent chooses continuation coverage and pays the applicable premium within the time period specified in the qualifying event notice, the University is required to provide coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated active employees or family members. If the University changes or ends group health coverage for similarly situated active employees, your coverage will also change or end.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Qualified beneficiaries do not have to show that they are insurable in order to choose continuation coverage. But a qualified beneficiary must have been actually covered by the Plan the day before the qualifying event in order to elect COBRA coverage.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent).

When and how must payment for continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage at the time of your election. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date your election notice is postmarked, if mailed.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make your first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the COBRA Administrator to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to the COBRA Administrator

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Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the 1st of every month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Periodic payments for continuation coverage should be sent to the COBRA Administrator

Grace periods for periodic payments

Although periodic payments are due on the 1st of each month, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. 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.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

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

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PART FIVE: RECOVERY PROVISIONS

Refund of overpayments

Whenever a payment has been made under any Coverage Feature in a total amount, at any time, in excess of the maximum amount payable under the Plan's provision ("Overpayment"), you or any other Covered Person must refund to the Plan the applicable Overpayment and help the Plan obtain the refund of 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.

In case of a recovery from a source other than the Plan, Overpayment recovery will not be more than the amount of the payment. An Overpayment also occurs when payment is made from the Plan that should have been made under another group plan. In that case, the Plan may recover the payment from one or more of the following: any other insurance company, any other organization, or any person to or for whom payment was made.

The Plan may, at its option, recover the Overpayment by reducing or offsetting against any future benefits payable to the Covered Person or his/her survivors; stopping future benefit payments that would otherwise be due under the Plans (payments may continue when the Overpayment has been recovered); or demanding an immediate refund of the Overpayment from the Covered Person.

With respect to the ***Disability Feature*** the Plan Administrator reserves the right to recover funds related to disability benefits for any Overpayment when a Covered Person receives state benefits, including Workers' Compensation and Social Security benefits.

PART SIX: GENERAL INFORMATION ABOUT THE PLAN

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

General Plan Information

Suffolk University Health and Welfare Benefits Plan is the name of the Plan.

The University has assigned Plan Number **504** to your Plan.

The provisions of the Plan become effective on **January 1, 2011**.

The Plan Year **begins on January 1 and ends on December 31**.

See also Schedule A and the Welfare Benefit Contracts for more information on each Coverage Feature.

University Information

The University's name, address, and identification number are:

***Suffolk University
8 Ashburton Place
Boston, MA 02108
E.I.N.: 04-2133255***

Plan Administrator Information

The Plan Administrator is:

***Suffolk University
8 Ashburton Place
Boston, MA 02108
617-573-8415***

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions you may have about the Plan.

Service of Legal Process

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

***Suffolk University
8 Ashburton Place
Boston, MA 02108
617-573-8415***

Attn: Office of the General Counsel

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

Type of Welfare Plan

The Plan is intended to be an "employee welfare benefit plan" within the meaning of ERISA Section 3(1).

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Type of Administration

While the Plan Administrator administers the Plan generally, Plan administration varies for each Coverage Feature. Some Features furnished under the Plan are administered by the providers/insurers of the applicable Welfare Benefit Contract. Other Features are administered by the University. If you have questions about the Plan or any Coverage Feature, you may contact the Plan Administrator or the contact listed for a particular Coverage Feature on Schedule A.

Amendment of the Plan

The University reserves the power to amend the provisions of the Plan at any time and to any extent that it may deem advisable. Any amendment to the Plan shall be effected by a written instrument signed by an officer of the University, or his or her authorized delegate, and delivered to the Plan Administrator. Unless otherwise provided, any such amendment will be effective for all Participants, whether or not employed by the University or any other Participating Employer.

Termination of the Plan

Although the University has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, neither the University nor any other Participating Employer has any obligation whatsoever to maintain the Plan for any given length of time. The University may discontinue or terminate the Plan at any time without liability, by a written instrument signed by an officer of the University, or his or her authorized delegate, and delivered to the Plan Administrator.

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PART SEVEN: YOUR ADDITIONAL RIGHTS

Your Rights Under ERISA

General Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain copies of all Plan documents and other Plan information including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies;
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report;
- Continue coverage under any group health plan subject to COBRA for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You, your spouse, or your dependents may have to pay for such coverage. See Part Four of the Plan;
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Group Medical Coverage Feature, if you have creditable coverage from another plan; and
- A certificate of creditable coverage, free of charge, when you lose coverage under the Group Medical Coverage Feature, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants. No one, including the University, a Participating 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.

Enforce Your Rights

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

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

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the Court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, including COBRA, HIPAA and other laws affecting the Plan or need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration: (866) 444-EBSA. You may also visit their website at www.dol.gov/ebsa.

Certificates of Coverage for Terminating Participants

Certificates of coverage are written documents provided by the Group Medical Coverage Feature to show the type of health care coverage a person had (e.g., employee only, employee plus spouse, etc.) and how long the coverage lasted. Under Federal law, most group health plans must provide these certificates automatically when a person's coverage terminates. However, if you do not receive a certificate, you have the right to request one. Certificates must be available to both Participants and participating Eligible Dependents. The primary purpose of the certificates is to show the amount of "Creditable Coverage" that you had under the Group Medical Coverage Feature because this can reduce or eliminate the length of time that any preexisting condition clause in a new plan otherwise might apply to you. The Group Medical Coverage Feature will automatically give you a certificate after you lose coverage (whether regular coverage or COBRA continuation coverage) and will make reasonable efforts to provide on the certificate the names of your Eligible Dependents who were also covered under the Group Medical Coverage Feature. The Group Medical Coverage Feature will provide automatic certificates for your Eligible Dependents when it has reason to know that they are no longer covered. In addition, the Group Medical Coverage Feature will provide a certificate for you (or your Eligible Dependents) upon request if you make the request within two years (24 months) after your coverage under the Group Medical Coverage Feature terminates. The Plan Administrator can give you forms to make such a request. In accordance with Federal law, the certificate of coverage will only show your coverage under the Group Medical Coverage Feature on or after July 1, 1996. See the Plan Administrator for information about confirming any coverage you had before that date.

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Rights for Participants who are Absent on Military Leave: USERRA

If you take a military leave of absence - whether for active duty or for training - you are entitled to continue your coverage under certain Coverage Features pursuant to the Uniformed Services Employment and Reemployment Rights Act ("USERRA").

Leave less than 31 days. If you are absent from work due to a period of active duty in the military for less than 31 days, your participation in any applicable Coverage Feature will not be interrupted, subject to your payment during such period of your regular Employee contribution for such coverage.

Leave 31 days or greater. If your absence extends for 31 days or greater, you may continue to maintain your coverage under an applicable Coverage Feature for up to 24 months from the date your absence for purpose of performing military service began. The University may require you to pay up to 102% of the full premium under each selected Coverage Features, which represents the University's share and your share, plus 2% for administrative costs.

Notice of election. The Plan Administrator may develop reasonable procedures addressing how continuing coverage may be elected, consistent with the terms of the Plan and USERRA. If you think you may be affected by USERRA, contact the Plan Administrator.

Coordination with COBRA. USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available. However, you should contact your Plan Administrator for more information, since a continuation of coverage under COBRA may be available to your spouse or dependent children in certain circumstances.

Rights For Participants on Family Leave under the FMLA

FMLA may entitle you, subject to certain eligibility requirements, to take a job-protected leave for your own serious illness, for the birth or adoption of a child, or to care for a spouse, domestic partner, child or parent who has a serious health condition. If you are the spouse, son, daughter, parent or next of kin for a covered service member, extended FMLA leave may be available to care for that service member. If you take a leave of absence that qualifies under the FMLA, you may continue your participation in any Coverage Feature subject to continued coverage under FMLA so long as you continue to contribute your share of the cost of coverage during the leave. Your monthly contributions during FMLA leave will be made pursuant to procedures established by the Plan Administrator. If you lose any coverage during any FMLA leave because you did not make the required contributions, you may re-enroll when you return from your leave. Your coverage will start again on the first day after you return to work and pay the required contributions.

Genetic Nondiscrimination

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of individuals or their family members. To comply with this law, the Plan Sponsor is asking you not to provide any genetic information when responding to any request for medical information under the Plan. "Genetic information" that should not be disclosed pursuant to GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, genetic information of a fetus carried by an individual or an individual's family member, and genetic information of an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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Availability of Health Insurance Marketplace under PPACA

When key parts of PPACA take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace (the “Marketplace”). To assist you as you evaluate options for you and your family, this section provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by PPACA, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments; for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please contact the Human Resources Office at 617-573-8415 or at 8 Ashburton Place, Boston, MA 02108.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost, please visit HealthCare.gov for more information including an online application for health insurance coverage and contact information for a Marketplace in your area.

The University reserves the right to amend this Plan at any time or from time-to-time without the consent of any Eligible Employee, Participant, dependent or beneficiary. Although the University expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan or any Plan Coverage Feature at any time without liability.

PART EIGHT - MISCELLANEOUS PROVISIONS

- Nothing contained in the Plan nor any action taken hereunder shall be construed as a contract of employment or as giving any Eligible Employee any right to be retained in the employ of the University or any Participating Employer.
- A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.
- Headings and numbers in this Plan are included for convenience of reference only, and if there shall be any conflict between any of the numbers and headings and the text of the Plan, the text shall control.
- Participants shall provide the Plan Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.
- Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Participant or other person any legal or equitable right against the Plan Administrator, the University or any of the Participating Employers, and in no event will the terms of employment or service of any Eligible Employee be modified or in any way affected hereby.
- The Plan is maintained for the exclusive benefit of the Participants.
- No employee of the University or any other Participating Employer, whether or not a Participant in, or eligible to participate in, the Plan, nor any Eligible Dependent, shall at any time have any vested rights to benefits provided under the Plan or under any Welfare Benefit Contract.
- To the extent any Coverage Feature under the Plan is self-insured by any Participating Employer, the benefits provided hereunder will be paid solely from the general assets of the Participating Employer. Nothing herein will be construed to require the Participating Employers or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant in this Plan, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Participating Employers from which any self-insured benefit payment under the Plan may be made.
- The University shall act for and on behalf of any and all Participating Employers in all matters pertaining to the Plan, and every act done by, agreement made with, or notice given to the University shall be binding on all such Participating Employers.
- To the extent not preempted by ERISA or any other federal statutes or regulations, this Plan shall be governed by, and construed in accordance with, the laws of *Massachusetts*.
- The University does not guarantee and is not responsible for the nature or quality of the goods or services provided through any health care provider or program.
- To verify whether a particular service is covered under a Coverage Feature, please contact the applicable provider or administrator set forth on Schedule A and seek written verification of the coverage determination.

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PART NINE - GLOSSARY OF TERMS

“Annual Enrollment Period” means *November 1 to November 30*.

“COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as described in Part Four.

“COBRA Administrator” means the party who administers COBRA continuation coverage, as identified in Part Four.

“Code” means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.

The “University” means *Suffolk University* and any successor to all or a major portion of its assets or business that assumes the obligations of *Suffolk University* under the Plan.

“Coverage Feature” means a health and welfare benefit offered under the Plan, and may include “Non-Contributory Coverage Features,” which are paid for by the University, and “Contributory Coverage Features,” which require you to contribute towards the cost.

“Covered Person” means a Participant as well as any Eligible Dependent or beneficiary who is or becomes covered under one or more Coverage Features.

“Dependent Child” shall mean the child of a Participant who:

- Is an Eligible Dependent; and
- Was enrolled in the Group Medical Coverage Feature, on the basis of being a student at a postsecondary educational institution (including an institution of higher education as described in Section 102 of the Higher Education Act of 1965), immediately before the first day of a Medically Necessary Leave of Absence.

“Domestic Partner Benefits Policy” means the policy outlining the domestic partner benefits provided by the University, including the terms, limitations and tax consequences of such benefits, as described in Part One.

Your “Eligible Dependents” must be U.S. Citizens or legal residents and generally are:

- Your lawfully married spouse, or your common-law spouse if you live in a state that recognizes common law marriages; if you are legally separated or divorced, your spouse is not an eligible dependent unless either mandated by state law or, with respect to a Coverage Feature, expressly deemed to be an Eligible Dependent under the Welfare Benefit Contract of such Coverage Feature;
- Your domestic partner; see “Enrollment of Domestic Partners” in Part One;
- Your domestic partner’s eligible dependents; see “Enrollment of Domestic Partners” in Part One;

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- For purposes of coverage under (1) the Group Medical Coverage Feature, (2) the Group Dental Coverage Feature and (3) any other Coverage Feature that provides for medical care of dependents that is excludable under Code Sections 105(b) and 106, any child of a covered Eligible Employee who has not attained age 26. A “child” of an Eligible Employee includes a biological child, stepchild, legally adopted child, or foster child placed with the eligible employee by judgment, decree, or other order of any court of competent jurisdiction. A “child” does not include the spouse or children of an Eligible Employee’s child.
- With respect to a Coverage Feature, any individual expressly deemed to be an Eligible Dependent under state law or under the Welfare Benefit Contract of such Coverage Feature.

You are an “Eligible Employee” if:

- You work in the United States for a Participating Employer and
- For purposes of coverage under (1) the Group Medical Coverage Feature and (2) the Group Dental Coverage Feature, you are an administrative, administrative/technical, support, support/technical, facilities or university police who is regularly scheduled to full-time 30 or more hours per week or part-time 21-29 hours a week in a regularly budgeted position, you are a titled full-time faculty member or you are in a phased retirement agreement. Lecturers and adjunct faculty governed by the Suffolk Affiliated Faculty AAUP Collective Bargaining Agreement who have taught two or more courses of three credits or more in the spring and fall semesters for ten or more consecutive semesters are eligible to participate if they complete an affidavit each year indicating they are not eligible for health insurance coverage through another employer or the employer of their spouse or same sex domestic partner. To remain eligible to continue Plan participation from year to year, as of every January 1, lecturers or adjunct faculty must have taught two or more courses of three credits or more in the spring and fall semesters of the past year and must be scheduled to teach two or more courses of three credits or more in the coming spring semester.
- For purposes of coverage under (1) the Healthcare Flexible Spending Account Feature, you are an administrative, administrative/technical, support, support/technical, facilities or university police who is regularly scheduled to work at least 21 hours per week in a regularly budgeted position or you are a titled faculty full-time member.
- For purposes of coverage under (1) the Life and Accidental Death & Dismemberment Feature, (2) the Long Term Disability Feature, (3) the Supplemental Life Feature and (4) the Employee Assistance Program Feature you are an administrative, administrative/technical, support, support/technical, facilities or university police who is regularly scheduled to work 21 or more hours a week in a regularly budgeted position, you were employed by the Company prior to January 1, 2015 working 17.5 hours or more per week in a regularly budgeted position, or you are a titled faculty member (professor, associate professor, assistant professor, instructor).
- You meet any other eligibility requirements for a Coverage Feature, as set forth on Schedule A or in the applicable Welfare Benefit Contract and
- You are not:
 - Engaged under an agreement that states you are not eligible to participate in the Plan or a Coverage Feature;

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- Employed on a foreign campus of the Employer;
- A non-resident alien performing services outside the United States;
- In a position dependent upon student status;
- Classified by the University as a temporary employee;
- Classified by the University as an independent contractor or consultant; or
- Employed by a staffing firm.

“ERISA” means the Employee Retirement Income Security Act of 1974, as amended from time to time.

“Excepted Benefit” means a benefit described in Section 732(c) of ERISA and the regulations promulgated thereunder.

“External Review” means an independent, External Review of an Adverse Benefit Determination under a Non-Grandfathered Group Medical Coverage Feature as required by PPACA.

“FMLA” shall mean the Family and Medical Leave Act of 1993, as amended.

“Grandfathered” means the Plan is “grandfathered” within the meaning of § 1251 of PPACA.

“Group Dental Coverage Feature” shall be as designated on Schedule A.

“Group Medical Coverage Feature” shall be as designated on Schedule A.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

“HMO” shall mean a Health Maintenance Organization.

“Human Resources Department” shall mean Director of Human Resources at Suffolk University, 8 Ashburton Place, Boston, MA, 02108, 617-573-8415.

“Increased Cost Exemption” means an exemption from the mental health and substance abuse parity rules set forth in Part 2 due to increased costs of providing such coverage, as determined in accordance with Section 712(c)(2) of ERISA.”

“Medically Necessary Leave of Absence” shall mean a leave of absence of a Dependent Child from a postsecondary educational institution (including an institution of higher education as described in Section 102 of the Higher Education Act of 1965), or any other change in enrollment of such child at such an institution, that:

- Commences while such Dependent Child is suffering from a serious illness or injury;
- Is medically necessary; and
- Causes such Dependent Child to lose student status for purposes of coverage under the Group Medical Coverage Feature.

No leave is of absence (or other change of enrollment) shall be considered a Medically Necessary Leave of Absence unless the Plan receives written certification by a treating physician of the Dependent Child that the Dependent Child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary.

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“MHPA” means the Mental Health Parity Act of 1996, as amended from time to time and as described in Part Two.

“Non-Grandfathered” means, with respect to a Group Medical Coverage Feature, that such Coverage Feature is not “grandfathered” within the meaning of §1251 of PPACA.

“Overpayment” shall be as defined in Part Five.

“Participant” means an Employee or Eligible Dependent who is eligible under a Welfare Benefit Contract to participate in a Coverage Feature and becomes covered under such Coverage Feature either automatically or through his or her enrollment, as applicable. For the purposes of the Health and Dental Coverage Features, Participant may also mean any spouse under the age of 65 of a Participant of the Suffolk University Retiree Health Plan. The term “Spouse” shall include domestic partners.

“PHI” shall mean “Protected Health Information” as defined in 45 C.F.R. §164.501.

“Plan” means the **Suffolk University Health and Welfare Benefit Plan (Plan Number 504)** as set forth herein (including any and all amendments and supplements hereto) and the Welfare Benefit Contracts, which are incorporated by reference into the Plan.

“Plan Administrator” means the University or such other person or committee as may be appointed from time to time by the University to supervise the administration of the Plan.

“Post-Service Claims” shall have the meaning set forth on Schedule C.

“PPACA” means, collectively, the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010.

“Pre-Service Claims” shall have the meaning set forth on Schedule C.

“QMSCO” means a Qualified Medical Child Support Order, as described in Part One.

The “Regulation” shall mean the “Standards for Privacy of Individually Identifiable Health Information” under the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, and applicable guidance.

“SSA” means the United States Social Security Administration.

“Urgent Care Claims” shall have the meaning set forth on Schedule C.

“USERRA” means the Uniformed Services Employment and Reemployment Rights Act of 1994.

“Welfare Benefit Contract” means any contractual arrangement maintained by the University, and described on Schedule A, under which group health or other welfare benefits are available to Employees and their eligible dependents, including any description of benefits, certificate of coverage, summary plan description, subscriber agreement, evidence of coverage, or other related materials relating to such benefits.

“The “Wellstone Act” shall mean the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended from time to time, and any regulations and guidance issued thereunder including, without limitation, 29 CFR §2590.712.”

The University reserves the right to amend this Plan at any time or from time-to-time without the consent of any Eligible Employee, Participant, dependent or beneficiary. Although the University expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan or any Plan Coverage Feature at any time without liability.

“WHCRA” means the Women’s Health and Cancer Rights Act of 1998, as described in Part Two.

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IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan to be executed in its name and on its behalf this __ day of _____, 2015 by a duly authorized officer of the Plan Sponsor.

Suffolk University

By: _____

Name: _____

Title: _____

The University reserves the right to amend this Plan at any time or from time-to-time without the consent of any Eligible Employee, Participant, dependent or beneficiary. Although the University expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan or any Plan Coverage Feature at any time without liability.

SUFFOLK UNIVERSITY
HEALTH AND WELFARE BENEFITS PLAN

Schedule B

Group Medical Coverage Feature: Full Time Employee Policy

Effective *January 1, 2015*

Introduction

For purposes of the Group Medical Coverage Feature, you are considered to be a “full time” employee of the Company if you are a common law employee of the Company and you perform, on average, at least 30 hours of service per week for the Company. Hours of service include each hour for which you are paid, or entitled to payment, by the Company for the performance of duties for the Company, as well as each hour for which you are paid, or entitled to payment, by the Company on account of 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. Hours of service you perform for certain entities aggregated with the Company under Code Sections 414(b), (c), (m) and (o) are also considered to be hours of service for the Company.

The Company counts hours of service from records of hours worked and hours for which payment is made or due.

How We Determine Full-Time Status

New Employees

New employees are not considered to be “full time” on their start dates. Rather, the Company will use lookback/measurement periods in order to determine whether and when new employees are considered to be “full time”.

The initial measurement period for new employees is a period of **12 months** beginning on the employee’s start date, or on any date up to and including the first day of the first calendar month following the employee’s start date (or on the first day of the first payroll period starting on or after the employee’s start date, if later). The initial measurement period is immediately followed by an administrative period of 90 days, provided that the initial measurement period and administrative period together cannot extend beyond the last day of the first calendar month beginning on or after the first anniversary of the employee’s start date.

The administrative period is then immediately followed by a stability period during which the new employee either is or is not considered to be a full-time employee of the Company, as follows:

- If a new employee averages at least 30 hours of service per week during the initial measurement period, the employee will be considered to be a full-time employee during a stability period beginning immediately after the initial measurement period (plus any administrative period) of **12 months**.
- If a new employee averages less than 30 hours of service per week during the initial measurement period, the employee will not be considered to be a full-time employee during a stability period beginning immediately after the initial measurement period (plus any administrative period) of **12**

months, provided that the stability period may not exceed the remainder of the first entire standard measurement period (as defined below).

Ongoing employees

An ongoing employee is an employee who has been employed by *Suffolk University* for at least one full standard measurement period. The Company's standard measurement period *begins on October 1 and ends on September 30 each year*.

The standard measurement period is followed by an administrative period of *90 days*. The administrative period is then followed by a stability period during which the new employee either or is not considered to be a "full time" employee of the Company, as follows:

- If an ongoing employee averages at least 30 hours per week during a standard measurement period, he/she must be treated as a full-time employee during a stability period of *12 months*.
- If an ongoing employee averages less than 30 hours per week during the standard measurement period, he/she may be treated as not a full-time employee during a stability period of *12 months*.

Transition from New to Ongoing Employee Status

Once a new employee has been employed for an entire standard measurement period, the Company will begin testing the employee for "full time" status in the same manner as ongoing employees. In addition, the following rules apply:

- If an employee is determined to be "full time" during the initial measurement period, he/she remains "full time" for the entire stability period associated with the initial measurement period.
- If, however, an employee is determined to be not "full time" during the initial measurement period, but is considered "full time" during the overlapping standard measurement period, the "not full time" stability period is cut short and the employee is considered "full time" for the stability period associated with the standard measurement period.

Other Applicable Rules

Employees Terminated and Rehired

If you terminate employment with the Company and are rehired by the Company, you will be treated as a new hire only if the period between the termination and rehire exceeds the lesser of:

- 26 consecutive weeks , or
- A period of no less than four weeks and at least as long as the employee's period of employment prior to termination.

Unpaid Leaves of Absence

Unpaid FMLA, jury duty and USERRA leave are credited with hours of service at a rate equal to the average weekly rate at which the employee was credited with hours of service during weeks in the measurement period that were not part of such leaves

SUFFOLK UNIVERSITY HEALTH AND WELFARE BENEFITS PLAN

Schedule C

Default Internal Claims Procedures

With respect to any Coverage Feature, the claims procedures on this Schedule C will apply if, and only if:

- the Welfare Benefit Contract with respect to the Coverage Feature does not contain a claims procedure, or
- the Coverage Feature has no Welfare Benefit Contract, or
- The Welfare Benefit Contract with respect to the Coverage Feature contains a claims procedure, but the procedure fails to comply with DOL Regulation 2560.503-1 or PPACA.

In any of these situations applies to a Coverage Feature, claims for benefits and subsequent appeals under that Coverage Feature shall be filed in accordance with the procedures set forth on this Schedule C.

Initial Claim

A Participant may initiate a claim for benefits under a Coverage Feature by contacting the Plan Administrator. The Plan Administrator will inform the Participant of the information needed to complete the claim, which may vary depending on the Coverage Feature and which may include:

- A completed claim form, in a form provided by the Plan Administrator;
- Reasonable documentation from the Participant's physician or other provider or official describing and/or verifying the injury, illness, or other condition or event giving rise to the Participant's claim;
- Copies of bills for services rendered, including the Participant's name, the name, address and telephone number of the provider, the diagnosis, the type of services rendered, with diagnosis and/or procedure codes, the date of services, and the charges.

Claims should be filed with the Plan Administrator within 60 days of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

- (a) it is not reasonably possible to submit the claim in that time; and
- (b) the claim is submitted within one year from the date incurred.

The Plan Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the Participant. The Plan reserves the right to have a Participant seek a second medical opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review.

Timing of Initial Decision

Calculating Time Periods

The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the procedures set forth above, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a Participant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Participant until the date on which the Participant responds to the request for additional information.

General Claims

The following claims procedure will apply to claims *other than* claims made for benefits under a group health plan or for disability benefits under one or more Coverage Features.

Under normal circumstances, within 90 days after the Plan Administrator receives your claim for benefits, the Plan Administrator will notify you, in writing, about its decision on your claim.

If special circumstances require longer than 90 days to process the claim, the Plan Administrator may take up to another 90 days to send you a notice of its decision. In that case, the Plan Administrator will send you a written notice of the need for an extension before the end of the first 90-day period. The notice will include the reason for the extension and the date by which a final decision is expected to be made.

Disability Claims

The following claims procedure will apply specifically to claims made for disability benefits under one or more Coverage Features.

If a claim under the Coverage Feature is denied in whole or in part, you or your beneficiary will receive written notification within a reasonable period of time, but no later than 45 days after the Plan Administrator's receipt of the claim. The Plan Administrator may extend this period for up to 30 additional days provided the Plan Administrator determines that the extension is necessary due to matters beyond the Plan Administrator's control and the Participant is notified, before the end of the initial 45-day period of the circumstances requiring the extension and of the date by which the Plan Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Plan Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision. Any extension notice will explain the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, you must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information.

Claims under a Group Health Plan

The following claims procedure will apply specifically to claims made for benefits under a group health plan.

Post-Service Claims

“Post-Service Claims” are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice of the claim decision (whether or not adverse) from the Plan Administrator within a reasonable period of time, but not later than 30 days, following the receipt of the claim, as long as all needed information was provided with the claim.

The Plan Administrator will notify you of its determination within 30 days after the claim is received, unless the Plan administrator determines, in its discretion, that special circumstances require an extension of time for processing the claim. If an extension of time is required, a written or electronic extension notice indicating the special circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision shall be furnished to you prior to the end of the initial 30-day period. If the extension is necessary because of your failure to provide missing information and you are notified of that fact, the extension shall not exceed a period of 15 days beginning as of the earlier of (i) the date the missing information is received by the Plan Administrator or (ii) the end of a 45-day period afforded to you to provide the missing information. If all of the needed information is received within the 45-day time frame, the Plan Administrator will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

If the extension is requested for reasons other than your failure to provide missing information, the extension shall not exceed 15 days from the end of the initial 30 day period.

Pre-Service Claims

“Pre-Service Claims” are those claims that require notification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision (whether or not adverse) from the Plan Administrator within a reasonable period of time, but not later than 15 days, following the receipt of the claim. If you filed a Pre-Service Claim improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 5 days of receipt of the pre-service claim.

The Plan Administrator will notify you of its determination within 15 days after the claim is received, unless the Plan administrator determines, in its discretion, that special circumstances require an extension of time for processing the claim. If an extension of time is required, a written or electronic extension notice indicating the special circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision shall be furnished to you prior to the end of the initial 15-day period. If the extension is necessary because of your failure to provide missing information and you are notified of that fact, the extension shall not exceed a period of 15 days beginning as of the earlier of (i) the date the missing information is received by the Plan Administrator or (ii) the end of a 45-day period afforded to you to provide the missing information. If all of the needed information is received within the 45-day time frame, the Plan Administrator will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

If the extension is requested for reasons other than your failure to provide missing information, the extension shall not exceed 15 days from the end of the initial 15 day period.

Urgent Claims That Require Immediate Action

“Urgent Care Claims” are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination (whether or not adverse) in writing or electronically as soon as possible taking into account the medical exigencies, but not later than 72-hours after the Plan Administrator receives all necessary information.
- Notice of denial may be oral with a written confirmation to follow within 3 days.

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

In determining whether a claim is urgent, the Plan Administrator shall defer to the determination of a Participant’s attending provider.

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

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

Special Rules for Concurrent Decisions

1. Participant’s request to extend previously approved course of treatment.

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

Non-Urgent care. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and a request to extend treatment is not an Urgent Care Claim, the request will be considered a new claim and decided according to the post-service or pre-service timeframes described above, whichever applies.

2. Plan reduces or terminates a previously approved course of treatment.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the Plan reduces or terminates such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments, the reduction or termination shall be considered an Adverse Benefit Determination (as defined below) and you shall be notified of the reduction or termination (sufficiently in advance of the termination or reduction to appeal the decision and obtain a determination upon review of the decision) before the course of treatment is reduced or terminated.

Notice of Initial Internal Adverse Benefit Determination

If (1) your claim is wholly or partially denied, or (2) if there occurs a rescission of coverage (within the meaning of Public Health Service Act Section 2712) under a Non-Grandfathered Group Medical Coverage Feature subject to PPACA (each, an Adverse Benefit Determination and the initial claim denial, an “Initial Internal Adverse Benefit Determination”) the Plan Administrator will furnish the Participant with a written notice of the Adverse Benefit Determination. The written notice will set forth the following information, in a manner calculated to be understood by the Participant:

- (a) The specific reason or reasons for the Initial Internal Adverse Benefit Determination;
- (b) Specific reference to those Plan provisions on which the Initial Internal Adverse Benefit Determination is based;
- (c) A description of any additional information or material necessary to perfect the claim and an explanation of why such material or information is necessary;
- (d) Appropriate information as to the steps to be taken if you wish to submit the claim for review;
- (e) In the case of an Initial Internal Adverse Benefit Determination by a group health plan or a plan providing disability benefits:
 - If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Initial Internal Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request;
 - If the Initial Internal Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- (f) In the case of an Initial Internal Adverse Benefit Determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

- (g) A statement indicating that the Participant shall be provided, upon request and free of charge, with reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits.
- (h) In the case of an Initial Internal Adverse Benefit Determination by a Non-Grandfathered Group Medical Coverage Feature subject to PPACA:
- The Group Medical Coverage Feature must ensure that any notice of Initial Internal Adverse Benefit Determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable)).
 - The Participant shall be provided, upon request and free of charge, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the notice shall contain a statement to such effect.
 - The Group Medical Coverage Feature must ensure that the reason or reasons for the Initial Internal Adverse Benefit Determination includes the denial code and its corresponding meaning, as well as a description of the group health plan's standard, if any, that was used in denying the claim.
 - The Group Medical Coverage Feature must provide a description of available internal appeals and External Review processes, including information regarding how to initiate an appeal.
 - The Group Medical Coverage Feature must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and External Review processes.
 - Notices will be provided in a culturally and linguistically appropriate manner.

Appeals of Initial Internal Adverse Benefit Determination

If you disagree with a claim determination after following the above steps, you can contact the Plan Administrator in writing to formally request an appeal. In your appeal, you may submit written comments, documents, records, and other information relating to your claim for benefits. You shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review of your claims shall take into account all comments, documents, records, and other information you submit, without regard to whether such information was submitted or considered in the initial benefit determination. With respect to a claim for benefits under a group health plan or a claim for disability benefits, the Plan will identify, upon request to the Plan Administrator, any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your Initial Internal Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of health care service(s).
- The provider's name.

- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

General Claims

The following appeals procedure will apply to claims *other than* claims made for benefits under a group health plan or for disability benefits under one or more Coverage Features.

You may appeal any denial of a claim within 60 days of receipt of such a denial by submitting a written request for review to the Plan Administrator.

Disability Claims and Claims under a Group Health Plan

The following appeals procedure will apply to claims made for benefits under a group health plan or for disability benefits under one or more Coverage Features.

You may appeal any denial of a claim within 180 days of receipt of such a denial by submitting a written request for review to the Plan Administrator.

The review of your appeal shall not afford deference to the Initial Internal Adverse Benefit Determination and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Initial Internal Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual. In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the Initial Internal Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.

In the case of a claim under a group health plan involving urgent care, you are entitled to an expedited review process pursuant to which--

- You may submit a request for an expedited appeal of an Initial Internal Adverse Benefit Determination orally or in writing; and
- All necessary information, including the Plan's benefit determination on review, shall be transmitted from the Plan to you by telephone, facsimile, or other available similarly expeditious method.

Timing of Notification of Benefit Determination on Review

For purposes of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted below due to a Participant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the Participant until the date on which the Participant responds to the request for additional information.

General Claims and Disability Claims

The following appeals procedure will apply to claims *other than* claims made for benefits under a group health plan.

The Plan Administrator shall notify you of the Plan's benefit determination on review not later than 60 days (45 days, with respect to disability claims) after receipt of your request for review by the Plan, unless the Plan Administrator determines that special circumstances require an extension of time for processing the claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to you prior to the termination of the initial 60-day (or 45-day) period. In no event shall such extension exceed a period of 60 days (45 days, with respect to disability claims) from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.

In the case of a Plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, the above paragraph shall not apply, and, the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator shall provide you with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator shall notify you, in of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

Claims under a Group Health Plan

The following appeals procedure will apply to claims for benefits under a group health plan.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Plan Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You hereby consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

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

For appeals of Pre-Service Claims (as defined above), a first level appeal will be conducted and you will be notified by the Plan Administrator of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days from receipt of a request for appeal of a denied claim.

If you are not satisfied with the first level appeal decision of the Plan Administrator, you have the right to request a second level appeal from the Plan Administrator. Your second level appeal request must be submitted to the Plan Administrator within 60 days of the receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days from receipt of a request for review of the first level appeal decision.

For appeals of Post-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Plan Administrator of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision of the Plan Administrator, you have the right to request a second level appeal from the Plan Administrator. Your second level appeal request must be submitted to the Plan Administrator within 60 days of the receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with Urgent Claims, see “Urgent Claim Appeals That Require Immediate Action” below.

Please note that the Plan Administrator’s decision is based only on whether or not benefits are available under the Coverage Feature for the proposed treatment or procedure. The determination as to whether the pending health service is right for you is between you and your doctor.

Urgent Claim Appeals That Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your doctor should call the Plan Administrator as soon as possible. The Plan Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.
- With respect to a Non-Grandfathered Group Medical Coverage Feature required to provide a “federal external review process” under 29 CFR 2590.715-2719(d), if the Initial Internal Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an Internal Appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, you may file a request with the Plan Administrator for an “expedited external review” within the meaning of interim final regulations under section 2719 of the Public Health Service Act.

The Plan Administrator has the exclusive right to interpret and administer the provisions of the Plan. The Plan Administrator’s decisions are conclusive and binding. The Plan Administrator has final claims adjudication authority under the Plan.

Manner of Notification of Final Internal Benefit Determination

The Plan Administrator shall provide a Participant with written or electronic notification of a Plan's benefit determination on review. In the case of an Adverse Benefit Determination (a "Final Internal Adverse Benefit Determination"), the notification shall set forth, in a manner calculated to be understood by the Participant:

- (a) The specific reason or reasons for the Final Internal Adverse Benefit Determination;
- (b) Reference to the specific Plan provisions on which the Final Internal Adverse Benefit Determination is based;
- (c) A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;
- (d) A statement describing any voluntary appeal procedures offered by the Plan and the Participant's right to obtain the information about such procedures;
- (e) a statement of the Participant's right to bring an action under section 502(a) of ERISA; and
- (f) In the case of a group health plan or a plan providing disability benefits--
 - If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Final Internal Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Participant upon request;
 - If the Final Internal Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
 - The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
- (g) In the case of an Initial Internal Adverse Benefit Determination by a Non-Grandfathered Group Medical Coverage Feature subject to PPACA:
 - The Group Medical Coverage Feature must ensure that any notice of Initial Internal Adverse Benefit Determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable)).

- The Participant shall be provided, upon request and free of charge, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the notice shall contain a statement to such effect.
- The Group Medical Coverage Feature must ensure that the reason or reasons for the Initial Internal Adverse Benefit Determination includes the denial code and its corresponding meaning, as well as a description of the group health plan's standard, if any, that was used in denying the claim.
- The Group Medical Coverage Feature must provide a description of available internal appeals and External Review processes, including information regarding how to initiate an appeal.
- The Group Medical Coverage Feature must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and External Review processes.
- Notices will be provided in a culturally and linguistically appropriate manner.

General Rules

Voluntary Extensions

As described above, the Plan Administrator must decide your claim and/or appeal within certain timeframes, and the Plan Administrator may extend those timeframes in its discretion in certain circumstances. In addition, the Plan Administrator may request that you voluntarily agree to allow the Plan Administrator additional time extensions. You may allow or deny these additional "voluntary" extensions in your discretion.

Rules Generally Applicable to Claims under a Non-Grandfathered Group Medical Coverage Feature

The following appeals procedure applies to claims made for benefits under a Non-Grandfathered Group Medical Coverage Feature subject to PPACA under these Default Internal Claims Procedures.

- The Company must allow you to review the claim file and to present evidence as part of the internal claims and appeals process.
- Any decision regarding hiring, compensation, termination, promotion or similar matters with respect to an individual such as a claims adjudicator or a medical expert must not be based upon the likelihood that the individual will support a denial of benefits.
- The Group Medical Coverage Feature must provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the group health plan (or at the direction of the Group Medical Coverage Feature) in connection with your claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided (see Timing of Notification of Benefit Determination on Review, below) to give you a reasonable opportunity to respond prior to that date.

- Before the Group Medical Coverage Feature can issue a Final Internal Adverse Benefit Determination based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided (see Timing of Notification of Benefit Determination on Review, below) to give you a reasonable opportunity to respond prior to that date.

Authorized Representatives

Any reference in these procedures to “you” or the “Participant” is also a reference to the Participant’s or your authorized representative making a claim on his or her behalf. The Plan Administrator reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your and/or the Participant’s behalf.

Questions About Your Claims and Appeal Rights

For questions about your rights, these claims procedures, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

SUFFOLK UNIVERSITY HEALTH AND WELFARE BENEFITS PLAN

Schedule D

Default External Review Procedures

The procedures on this Schedule D apply only to Non-Grandfathered Group Medical Coverage Features subject to PPACA, and only if:

- the Welfare Benefit Contract with respect to the Coverage Feature does not contain an external review procedure, or
- the Coverage Feature has no Welfare Benefit Contract, or
- The Welfare Benefit Contract with respect to the Coverage Feature contains an external review procedure, but the procedure fails to comply with DOL Regulation 2560.503-1 or PPACA.

General. If the procedures on this Schedule D apply to your Group Medical Coverage Feature:

- You may be entitled to request an external review of a Final Internal Adverse Benefit Determination by the Plan (an “External Review”); and
- If your situation is urgent, you may be entitled to an Expedited External Review of an Adverse Benefit Determination by the Plan (an “Expedited External Review”).

For purposes of this Schedule D, an “Adverse Benefit Determination” means an adverse benefit determination as defined in 29 CFR 2560.503-1, as well as any rescission of coverage, as described in Sec. 54.9815- 2712T(a)(2) (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), and may be either an initial internal Adverse Benefit Determination (“Initial Internal Adverse Benefit Determination”) or an internal Adverse Benefit Determination made on appeal thereof (a “Final Internal Adverse Benefit Determination”).

Insured Non-Grandfathered Group Medical Coverage Features

If benefits are provided under the Plan through group health insurance coverage, the issuer must provide an External Review process as follows.

If a state External Review process applies to and is binding on the Plan or issuer, and the state process includes at a minimum (1) the 16 consumer protections in the NAIC Uniform Model Act described in the regulations issued on July 23, 2010 at 75 FR 43330 (as amended) or (2) the 13 Temporary standards set forth in Department of Labor Technical Release 2011-02, then the Company will comply with those state External Review processes. Otherwise, the Company may comply with either (1) the “HHS Administered Process” (as defined in the regulations issued June 24, 2011 at 76 FR 37208) or (2) the Federal External Review Process described below.

To the extent that benefits under the Plan are provided through such health insurance coverage, the Plan is not required to provide an External Review process in addition to that provided by the issuer.

Self-Insured Non-Grandfathered Group Medical Coverage Features

Each self-insured Non-Grandfathered Group Medical Coverage Feature may either (1) follow the Federal External Review Process described below or (2) voluntarily comply with a state External Review process, to the extent an applicable state has expanded access to its External Review to plans that are not subject to state insurance law.

Federal External Review Process

This Federal External Review Process follows interim guidance from the federal agencies that are responsible for PPACA, and apply until replaced by future guidance.

External Review under the Federal External Review Process is not available for all Adverse Benefit Determinations. For example, a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan is not eligible for External Review. In addition, with respect to claims for which External Review has not been initiated by September 20, 2011, the Federal External Review Process is suspended until further notice except for claims relating to rescissions (within the meaning of Public Health Service Act Section 2712) and/or medical judgment. The Plan Administrator further reserves the right to exclude from External Review additional types of Adverse Benefit Determination as may be permitted under PPACA and any related guidance issued from the federal agencies that are responsible for implementation of PPACA.

Any reference in these procedures to “you” or the “Participant” is also a reference to the Participant’s or your authorized representative making a claim on his, her or your behalf. The Plan Administrator reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your and/or the Participant’s behalf.

A. Standard External Review

Standard External Review is External Review that is not considered expedited (as described in paragraph B of this section).

1. Request for External Review. The Plan Administrator will allow you to file a request for an External Review with the Plan Administrator if the request is filed within four months after the date of receipt of a notice of an Adverse Benefit Determination. If there is no corresponding date four months after the date

of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five business days following the date of receipt of the External Review request, the Plan Administrator will complete a preliminary review of the request to determine whether you meet all of the following requirements for Standard External Review:

- (a) You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
- (b) The Adverse Benefit Determination does not relate to the your failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
- (c) You have exhausted the Plan's internal appeal process unless you are not required to exhaust the internal appeals process under applicable regulations; and
- (d) You have provided all the information and forms required to process an External Review.

Within one business day after completion of the preliminary review, the Plan Administrator will issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification must describe the information or materials needed to make the request complete and the Company will allow a Participant to perfect the request for External Review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to IRO. The Plan Administrator will assign an independent review organization ("IRO") that is accredited by URAC or a similar nationally-recognized accrediting organization to conduct the External Review. Moreover, the Plan Administrator will take action against bias and to ensure independence. Accordingly, the Plan Administrator will contract with IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). The Plan Administrator will contract with at least three IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

A contract between the Plan and an IRO will provide the following:

- (a) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.
- (b) The assigned IRO will timely notify the Participant in writing of the request's eligibility and acceptance for External Review. This notice will include a statement that the Participant may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

(c) Within five business days after the date of assignment of the IRO, the Plan Administrator will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan Administrator to timely provide the documents and information must not delay the conduct of the External Review. If the Plan Administrator fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify the Participant and the Plan Administrator.

(d) Upon receipt of any information submitted by the Participant, the assigned IRO will within one business day forward the information to the Plan Administrator. Upon receipt of any such information, the Plan Administrator may reconsider the Adverse Benefit Determination that is the subject of the External Review. Reconsideration by the Plan Administrator must not delay the External Review. The External Review may be terminated as a result of the reconsideration only if the Plan Administrator decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Plan Administrator must provide written notice of its decision to the Participant and the assigned IRO. The assigned IRO must terminate the External Review upon receipt of the notice from the Plan Administrator.

(e) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(i) The Participant's medical records;

(ii) The attending health care professional's recommendation;

(iii) Reports from appropriate health care professionals and other documents submitted by the Company or issuer, Participant, or the Participant's treating provider;

(iv) The terms of the Participant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

(v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(vi) Any applicable clinical review criteria developed and used by the Plan or the Plan Administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(vii) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(f) The assigned IRO must provide written notice of the final External Review decision within 45 days after the IRO receives the request for the External Review. The IRO must deliver the notice of final External Review decision to the Participant and the Plan.

(g) The assigned IRO's decision notice will contain:

- (i) A general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
- (ii) The date the IRO received the assignment to conduct the External Review and the date of the IRO decision;
- (iii) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- (iv) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- (v) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to the Participant;
- (vi) A statement that judicial review may be available to the Participant; and
- (vii) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act Section 2793.

(h) After a final External Review decision, the IRO must maintain records of all claims and notices associated with the External Review process for six years. An IRO must make such records available for examination by the Participant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

4. Reversal of Plan's decision. Upon receipt of a notice of a final External Review decision reversing the Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

B. Expedited External Review

1. Request for expedited External Review. The Plan must allow you to make a request for an expedited External Review with the Plan at the time you receive:

(a) An Initial Internal Adverse Benefit Determination that involves a medical condition of yours for which the timeframe for completion of an expedited internal appeal under the interim final regulations under Section 2719 of the Public Health Service Act would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

(b) A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a Standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited External Review, the Plan Administrator will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for Standard External Review. The Plan Administrator will immediately send a notice that meets the requirements set forth in paragraph A.2 above for Standard External Review to the Participant of its eligibility determination.

3. Referral to IRO. Upon a determination that a request is eligible for External Review following the preliminary review, the Company will assign an IRO pursuant to the requirements set forth in paragraph A.3 above for Standard External Review. The Plan Administrator will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for Standard External Review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final External Review decision. The Plan's contract with the assigned IRO must require the IRO to provide notice of the final External Review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the Participant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the IRO's notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Participant and the Plan.

Questions About Your Claims and Appeal Rights

For questions about your rights, these claims procedures, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).