

**VILLANOVA UNIVERSITY**  
**POST-65 RETIREE MEDICAL PLAN**  
**AND**  
**SUMMARY PLAN DESCRIPTION**

**Effective January 1, 2018**

## INTRODUCTION

Villanova University (the "University") maintains the Villanova University Post-65 Retiree Medical Plan (the "Plan"). This document describes the Plan as in effect as of January 1, 2018.

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

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

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

### OneExchange

This document frequently refers to "OneExchange." OneExchange is Willis Towers Watson's platform to provide access to a variety of individual health care plans. Villanova University has chosen OneExchange to provide eligible Plan participants and their Medicare-eligible spouses with the ability to select among the individual health care plans offered by OneExchange. OneExchange is not an insurance company, but a marketplace where you can select from a wide variety of Medicare plans from national and regional insurance companies. Beginning on January 1, 2018, the ability to choose among coverage options offered by OneExchange and the

University contribution described in this document replaces the group coverage that was previously offered to Medicare-eligible retirees and grandfathered Medicare-eligible spouses under the Plan. Note that it is anticipated that OneExchange will change its name to Via Benefits during the first quarter of 2018. If this change takes place, all references to OneExchange in this document will refer, instead, to Via Benefits.

## **PURPOSE OF THE PLAN**

The purpose of the Plan is to provide you (and, in some limited cases, your eligible spouse) with health benefits after your retirement from Villanova University.

## **ELIGIBILITY AND PARTICIPATION**

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

### **Eligible Retiree**

All full-time employees who retire from the University on or prior to May 31, 2018 at age 62 or older and who have completed 10 or more years of active credited service are eligible to participate in the Plan once they reach age 65. If you are a full-time employee who retires from the University after May 31, 2018 at age 62 or older and have completed 10 or more years of active credited service, you are eligible to participate in the Plan on a limited basis once you reach age 65. You and your Medicare-eligible spouse may enroll in an individual health care plan offered through OneExchange; however, you are not eligible for the University subsidy described in this document or any other University contribution towards the cost of your retiree health care coverage.

Full-time status is determined in accordance with the University's personnel policies and practices in force at the time of the determination of eligibility. A full-time employee who receives worker's compensation benefits and/or long-term disability benefits is eligible to participate in the Plan if he or she attained age 62 and completed at least 10 years of service with the University at the time of the injury or disability.

The following individuals are ineligible to participate in the Plan in any way: (1) part-time employees (*i.e.*, employees not considered "full-time"), (2) temporary employees, (3) those individuals who perform services for the University pursuant to an arrangement with a leasing organization, including but not limited to "leased employees," (4) those individuals who are not on the University payroll (such as consultants and independent contractors), whether or not they are later determined to be employees of the University, (5) other non-regular employees as determined in accordance with the University's personnel policies and practices, and (6) Augustinian priests.

To be eligible to participate in this Plan after age 65, you must enroll in Medicare Part A and Part B such that Medicare is the primary payer of medical benefits for you. The Plan Administrator reserves the right to request sufficient information from you to show that you are enrolled in Medicare.

### **Eligible Spouse**

Your spouse may receive coverage under the Plan by electing coverage in OneExchange. However, your spouse is not eligible for a University subsidy to this coverage and you or your spouse must pay the full cost of your spouse's coverage selected through OneExchange.

### **Participation**

If you are an eligible retiree, you may elect to participate in the Plan as of the first of the month following your retirement date. To become a participant, you must follow the enrollment process prescribed by the Plan Administrator and OneExchange, enroll in coverage through OneExchange and pay any required contribution(s). Once you make an election to participate in the Plan, you may change that election only (1) if you have a change in status, as described below under CHANGING YOUR ELECTION, or (2) during an open enrollment period at then applicable rates. If you fail to make an election to participate in OneExchange upon your *initial* eligibility for coverage, or drop coverage for a period of time, you may enroll or reenroll in coverage only (1) if you have a change in status, as described below under CHANGING YOUR ELECTION, or (2) during an open enrollment period at then applicable rates. If you fail to make an election for health coverage during an open enrollment period, you will be deemed to have elected to maintain the same health coverage elections (at then applicable rates) for the upcoming Plan Year. Therefore, it is extremely important that you enroll in the Plan within the time period prescribed by the Plan Administrator and OneExchange.

For coverage effective January 1, 2018, you and your spouse must enroll with OneExchange and make an election of coverage during the OneExchange enrollment period that closes prior to January 1, 2018. If you do not enroll and elect coverage through OneExchange during this period, any previous election of coverage you have made under the University's group health plan will not carry over to 2018 and you will receive no coverage.

### **CESSATION OF PARTICIPATION**

#### **Cessation of Participation for Eligible Retirees**

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

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

## **Cessation of Participation for Eligible Spouses**

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

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

## **COST OF COVERAGE**

If you elect coverage through OneExchange, the University will provide you with a \$1,300 annual subsidy toward the cost of your coverage. You must pay the difference between the monthly cost for the individual health plan in which you are enrolled through OneExchange and the University's contribution. The University sets the level of any University contributions and reserves the right to cease or change the level of University contributions at any time.

Note that if you retire mid-year between January 1, 2018 and May 31, 2018, you will receive only a prorated portion of the \$1300 annual subsidy towards the cost of your coverage for 2018.

### **Sunset of University Contributions under the Plan**

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

## **COVERAGE OPTIONS AND ENROLLMENT**

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

Generally, you may not make changes to your coverage elections during the Plan Year. (This restriction is due to requirements under federal law.) You may make a change to an election that

is on account of and consistent with one of the events described below. If you have a change in work status - sometimes referred to as a "Life Event" - or under certain other circumstances, you may join, re-join, opt out, if you notify the University within 30 days of the change (31 days in some cases, as described in separate written materials). The following list describes circumstances that may permit you to make a mid-year election change.

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

- Change in Marital Status - a change in your legal marital status (such as, legal separation, annulment, divorce or death of your spouse),
- Change in Employment Status - any of the following events that change the employment status of you or your spouse that affects benefit eligibility under another employee benefit plan of you or your spouse. Such events include any of the following changes in employment status: termination or commencement of employment; switching from part-time to full-time or vice versa; or any other similar change that makes the individual become (or cease to be) eligible for a particular benefit under the plan,
- Change in Residence - a change in your or your spouse's place of residence.

If a Life Event occurs, you must inform the Plan Administrator within 30 days of the Life Event. Your coverage change will be effective on the first day of the month after you provide timely notice to the Plan Administrator.

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

- Life Event Involving Coverage Eligibility Under Another Plan - For a Life Event in which you or your spouse gain eligibility for coverage under another employer's plan as a result of a change in your marital status or a change in your or your spouse's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Life Event only if coverage for that individual becomes effective or is increased under the other employer's plan.

***Change in Coverage.*** If the Plan Administrator notifies you that your coverage under the Plan will be *significantly* curtailed during the Plan Year, you may revoke your election and elect coverage under another plan option that provides similar coverage. You may also revoke your

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

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

## **BENEFITS**

This section briefly summarizes the benefits available under the Plan and describes some important rules regarding your annual elections under the Plan. For a more complete description of the benefits available under each coverage option, please refer to the separate descriptive booklets and other materials that you have received from OneExchange and the insurer of your individual health plan.

### ***Medical Subsidy***

The Plan has partnered with OneExchange to provide you with access to a variety of individual health care plans. OneExchange is not an insurance company, but rather a marketplace that works with carriers and retiree medical plans throughout the United States, and will assist you in choosing a plan that meets your individual needs. If you are eligible to participate in this Plan and you retire by May 31, 2018 and you select coverage for yourself through OneExchange, the Plan will contribute \$1,300 per year towards coverage under the individual health plan you select. You will continue to be responsible for the cost of coverage in excess of this \$1,300 contribution. You can use the \$1,300 contribution to reimburse your monthly medical insurance premiums, but the contribution cannot be used for prescription drug, dental, or vision premiums, or premiums for any spousal coverage.

The University contribution will be made on a tax-free basis through a Health Reimbursement Account ("HRA") established on your behalf by the University, if you enroll in coverage through OneExchange. Any remaining, unused funds in your HRA at the end of a Plan year will be forfeited. HRA funds do not rollover to the next year.

Special Rules Related to Pregnancy and Childbirth. The Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section, or require that a health care provider obtain authorization from the Plan or any insurance

issuer (including an HMO) for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother's attending provider, after consulting with the mother, from discharging the mother earlier than 48 hours (or 96 hours as applicable). This paragraph is required by law, and does not provide benefits to newborn children or other dependent children of eligible retirees.

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

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

### ***Life Insurance Benefits***

You will receive a life insurance benefit of \$5,000 regardless of whether you are enrolled in the medical coverage under this Plan. The cost of this benefit is paid entirely by the University. However, if you retire from employment with the University after May 31, 2018, you will not be entitled to this University-paid life insurance benefit.

## **CLAIMS AND APPEALS PROCEDURES**

The booklets and other materials that describe the individual health care benefits you have selected through OneExchange generally will contain a specific set of claims and appeals procedures that you must follow to make a claim to receive that particular benefit and/or to appeal a denied claim for that particular benefit. Although these separate claims and appeals procedures will be very similar in most respects, there may be important differences. As such,



you should follow the specific claims and appeals procedures for a particular benefit very carefully. If the booklets and other materials that describe a particular benefit do not contain a specific set of claims and appeals procedures, the Plan's default procedures as described below will apply. If you have any questions about which set of claims and appeals procedures to follow or any other questions about making a claim, you should contact the Plan Administrator immediately.

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

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

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

### **Claims Not Involving Medical Benefits**

In the case of a claim involving life insurance benefits, initial claims for benefits under the Plan shall be made by you in writing to the Claims Administrator.

- Time Periods for Responding to Initial Claims - If you bring a claim for benefits under the Plan, the Claims Administrator will respond to you within 90 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 90-day period that the Claims Administrator needs up to an additional 90 days to review your claim. The Claims Administrator will notify you within the initial 45-day period that the Claims Administrator needs up to an additional 30 days to review your claim.

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

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

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

### **Claims Involving Medical Benefits**

In the case of a claim involving medical benefits, initial claims for benefits under the Plan shall be made by you in writing to the Claims Administrator.

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

- *Post-Service Claim* - A “post-service claim” is a claim for payment for a particular benefit or for a particular service after the benefit or service has been provided. A post-service claim must contain the information requested on a claim form provided by the applicable provider.
- *Urgent Care Claim* - An “urgent care claim” is a claim for benefits or services involving a sudden and urgent need for such benefits or services. A claim will be considered to involve urgent care if the Claims Administrator or a physician with knowledge of your condition determines that the application of the claims review procedures for non-urgent claims (i) could seriously jeopardize your life or your health, or your ability to regain maximum function, or (ii) in your physician’s opinion, would subject you to severe pain that cannot adequately be managed without the care or treatment that is the subject of the claim.
- *Concurrent Care Review Claim* - A “concurrent care review claim” is a claim relating to the continuation/reduction of an ongoing course of treatment.
- Time Periods for Responding to Initial Claims - If you bring a claim for benefits under the Plan, the Claims Administrator will respond to your claim within the following time periods:
  - *Post-Service Claim* - In the case of a post-service claim, the Claims Administrator shall respond to you within 30 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 30-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is necessary because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.
  - *Pre-Service Claim* - In the case of a pre-service claim, the Claims Administrator shall respond to you within 15 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 15-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.
  - *Urgent Care Claim* - In the case of an urgent care claim, the Claims Administrator shall respond to you within 72 hours after receipt of the claim. If the Claims Administrator determines that it needs additional information to review your claim, the Claims Administrator will notify you within 24 hours after

receipt of the claim and provide you with a description of the additional information that it needs to evaluate your claim. You will have no less than 48 hours from the time you receive this notice to provide the requested information. Once you provide the requested information, the Claims Administrator will evaluate your claim within 48 hours after the earlier of the Claims Administrator's receipt of the requested information, or the end of the extension period given to you to provide the requested information. There is a special time period for responding to a request to extend an ongoing course of treatment if the request is an urgent care claim. For these types of claims, the Claims Administrator must respond to you within 24 hours after receipt of the claim by the Plan (provided, that you make the claim at least 24 hours prior to the expiration of the ongoing course of treatment).

- *Concurrent Care Review Claim* - If the Plan has already approved an ongoing course of treatment for you and contemplates reducing or terminating the treatment, the Claims Administrator will notify you sufficiently in advance of the reduction or termination of treatment to allow you to appeal the Claims Administrator's decision and obtain a determination on review before the treatment is reduced or terminated.
- Notice and Information Contained in Notice Denying Initial Claim - If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally). This notice will include the following:
  - *Reason for the Denial* - the specific reason or reasons for the denial;
  - *Reference to Plan Provisions* - reference to the specific Plan provisions on which the denial is based;
  - *Description of Additional Material* - a description of any additional material or information necessary for you to perfect your claim and an explanation as to why such information is necessary;
  - *Description of Any Internal Rules* - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
  - *Description of Claims Appeals Procedures* - a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will include a statement that you are eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal and a description of any expedited review process for urgent care claims).

- **Appealing a Denied Claim for Benefits** - If the Claims Administrator denies your initial claim for benefits, you may appeal the denial by filing a written request (or an oral request in the case of an urgent care claim) with the Appeals Administrator within 180 days after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Appeals Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your appeal.
  
- **Time Periods for Responding to Appealed Claims** - If you appeal a denied claim for benefits, the Appeals Administrator will respond to your claim within the following time periods:
  - *Post-Service Claim* - In the case of an appeal of a denied post-service claim, the Appeals Administrator shall respond to you within 60 days after receipt of the appeal.
  - *Pre-Service Claim* - In the case of an appeal of a denied pre-service claim, the Appeals Administrator shall respond to you within 30 days after receipt of the appeal.
  - *Urgent Care Claim* - In the case of an appeal of a denied urgent care claim, the Appeals Administrator shall respond to you within 72 hours after receipt of the appeal.
  - *Concurrent Care Review Claim* - In the case of an appeal of a denied concurrent care review claim, the Appeals Administrator shall respond to you before the concurrent or ongoing treatment in question is reduced or terminated.
  
- **Notice and Information Contained in Notice Denying Appeal** - If the Appeals Administrator denies your claim (in whole or in part), the Appeals Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally or via facsimile or other similarly expeditious means of communication). This notice will include the following:
  - *Reason for the Denial* - the specific reason or reasons for the denial;
  - *Reference to Plan Provisions* - reference to the specific Plan provisions on which the denial is based;
  - *Statement of Entitlement to Documents* - a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits;

- *Description of Any Internal Rules* - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
- *Statement of Right to Bring Action* - a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits.

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

#### **COBRA CONTINUATION OF COVERAGE and CONVERSION RIGHTS**

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that has several provisions designed to protect certain individuals against a sudden loss of health care coverage if there is a qualifying event that would cause the loss of health care coverage under the Plan. Because each individual enrolled in the Plan will have coverage through their own individual health care plan, no continuation coverage under COBRA will be available. Similarly, no conversion rights to an individual policy will be available because individuals enrolled in the Plan are already covered under individual health care policies.

#### **PLAN ADMINISTRATOR**

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

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

The decisions of the Plan Administrator (or its delegate) in all matters relating to the Plan (including, but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of

fact) will be final and binding on all parties and generally will not be overturned by a court of law.

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

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

### **ADDITIONAL INFORMATION**

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

Plan Name: Villanova University Post-65 Retiree Medical Plan

Plan Number: 503

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

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

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

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

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

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



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

**Type of Plan.** The Plan is a welfare benefit plan providing the following type of benefits: medical coverage and life insurance benefits.

**Administration.** The University's subsidy for medical coverage and the life insurance benefit are administered by the University. Health care benefits selected through OneExchange are administered by the various providers in accordance with the individual health care plan and coverage selected. The administrator for OneExchange may be contacted at 1-866-202-9420 or [Medicare.OneExchange.com/Villanova](http://Medicare.OneExchange.com/Villanova).

**Funding Medium.** The University subsidy for health care benefits under the Plan is funded through direct payments from the general funds of the Plan Sponsor to health reimbursement accounts established on behalf of Participants. Participants may use the funds in a health reimbursement account to offset the cost of medical coverage. The life insurance benefit under the Plan is funded through direct payments from the general funds of the Plan Sponsor.

### **THIRD PARTY LIABILITY**

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

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

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

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

## **NO ASSIGNMENT OF BENEFITS**

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

## **STATEMENT OF ERISA RIGHTS**

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

### *Receive Information About Your Plan and Benefits*

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for your spouse (if covered prior to July 1, 2001) if there is a loss of coverage under the Plan as a result of a qualifying event. Your spouse will have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

### *Prudent Actions by Plan Fiduciaries*

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

*Enforce Your Rights*

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

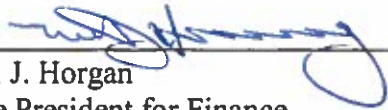
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up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

*Assistance With Your Questions*

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

**Villanova University herewith causes this Plan to be executed on the 12<sup>th</sup> day of December, 2017 by its duly authorized officer.**

**VILLANOVA UNIVERSITY**

By:   
Neil J. Horgan  
Vice President for Finance

## APPENDIX A

### HIPAA PRIVACY & PROTECTED HEALTH INFORMATION

The Plan is a hybrid entity for purposes of HIPAA. As such, the portion of the Plan that provides medical benefits is part of the health care component. The portion of the Plan that provides life insurance benefits is part of the non-health care component. References to the "Plan" in this section refer only to the health care component of the Plan, including any health insurance issuer or HMO that provides medical benefits pursuant to the Plan.

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

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

The Plan Sponsor needs access to PHI to:

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

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

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

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

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

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