# SUMMARY PLAN DESCRIPTION
# OF THE

## Drew University Health and Welfare Benefit Plan

*Originally Effective January 1, 2020*
*Amended and Restated Effective January 1, 2024*

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## INTRODUCTION

Drew University (hereinafter the "Employer") maintains the Drew University Health and Welfare Benefit Plan (the "Plan") for the exclusive benefit of Employees who meet the eligibility requirements. The Plan is a large, single plan that provides a variety of benefits. Those benefits are referred to herein as "Components." Some of the Components are subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and provisions of the Internal Revenue Code of 1986, as amended ("Code"). This Summary Plan Description ("SPD") describes the requirements imposed by ERISA and the Code, and describes the administrative framework for all of the benefits that are provided. This document and its Exhibits, including the certificates of coverage issued by the insurance companies and the summary plan descriptions issued by the third-party administrators and/or Plan Administrator, constitute the SPD for each of the Components to the extent required by ERISA § 102.

**Important**: This SPD is only a summary of the key parts of the Plan, and a brief description of your rights as a Participant of a Component benefit. Be sure to proceed through this SPD carefully, so that you can make informed decisions that are right for you.

The Plan provides benefits through the following Components, as described in Exhibit B:

*Drew University Medical Plan*
*Drew University Dental Plan*
*Drew University Vision Plan*
*Drew University Group Life/AD&D Plan*
*Drew University Long-Term Disability Plan*
*Drew University Supplemental Plan*
*Drew University Prepaid Legal Plan*
*Drew University Health Savings Account (HSA)*
*Drew University Health Flexible Spending Account (FSA)*
*Drew University Dependent Care FSA*

Each of these Components is summarized in a certificate of coverage booklet issued by an insurance company or a summary plan description issued by the third party administrators and/or Plan Administrator. A copy of each certificate of coverage or summary plan description is attached to this document in Exhibit B. ***This document plus the Exhibits and Attachments together are the SPD for the Plan. It is very important to check the Parts of Exhibit B relating to each Component.***

**Important**: Benefits under each Component are provided pursuant to an insurance contract and/or pursuant to a governing plan document adopted by the Employer. If the terms of this document conflict with the terms of such insurance contract or governing plan document, then the terms of the insurance contract or governing plan document will control, rather than this document, unless otherwise required by law.

## PART I.
## GENERAL INFORMATION ABOUT THE PLAN

### 1.1 What is the purpose of the Plan?

The purpose of the Plan is to provide certain Employees with an opportunity to receive certain benefits as part of an employee welfare benefit plan, as further described herein. You are being provided this document to give you an overview of the Plan and to address certain information that may not be addressed in the Exhibits.

### 1.2 When did the Plan take effect?

This Plan was originally adopted effective January 1, 2020. This SPD has been amended and restated effective January 1, 2024.

It operates on a "Plan Year" running from January 1 through December 31. It is important to note that some Components of the Plan may operate on a different Plan Year than the ERISA Wrap Plan Year identified above.

### 1.3 Who can participate in the Plan?

Each Employee of the Employer shall be eligible to participate in the Plan upon meeting the eligibility requirements (e.g., hourly work requirements, etc.) of any one of the applicable Components identified in Exhibit B. These employees are called "Eligible Employees." Those Eligible Employees who actually participate in one or more Components of the Plan are called "Participants." There are certain exceptions. They are described in the underlying Plan document. You will be notified if you fall within one of those exceptions.

**"Employee"** means a common-law employee of the Employer, except that the term "Employee" does not include any common-law employee who is a leased employee (including, but not limited to, an individual defined in Internal Revenue Code § 414(n)), or any common-law employee who is an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such person is on the Employer's W-2 payroll. The term "Employee" also does not include any individual who performs services for the Employer but who is paid by a temporary or other employment agency or any employee covered under a collective bargaining agreement unless the collective bargaining agreement so provides. The term "Employee" includes "former employees" for the limited purpose of allowing continued eligibility for benefits as provided hereunder after an employee ceases to be employed by the Employer.

To determine whether you are eligible to participate in a Component identified in Exhibit B, please read the eligibility information contained within the Exhibit for the applicable Component.

### 1.4 When do I become a Participant?

For newly Eligible Employees, participation may begin as described in each of the Components identified in Exhibit B. Participation dates may vary based upon the Component and classification of an Eligible Employee.

Special rules that limit entrance apply if you do not become a Participant in any of the Components identified in Exhibit B when first eligible. For some Components, you may become a Participant at the start of any subsequent Plan Year, subject to any applicable evidence of insurability requirements imposed by the Components. Other Components do not have regular entry dates. In addition, with certain Components, you may begin participation at other times under certain

circumstances. For example, see the description of HIPAA Special Enrollment that applies to the Component providing group health coverage described in Exhibit B.

### 1.5 Can others be covered through me?

Depending upon the terms and conditions of a particular Component, you may be able to have certain family members (e.g., child, spouse, etc.) covered through you. In order for other persons to be covered through you, you must be (and remain) a Participant in the Plan and under the particular Component(s).

### 1.6 What are the conditions of participation?

As a condition of participation and receipt of benefits under the Plan, you agree to:

(a) Observe all Plan rules and regulations;

(b) Consent to inquiries by the Plan with respect to any provider of services involved in a claim under the Plan;

(c) Submit to the Plan all notifications, reports, bills, and other information that the Plan may reasonably require;

(d) Agree to repay any overpayments or incorrect payments received through the Plan; and

(e) Agree to provide required proof or documentation regarding eligibility within thirty (30) days of the request.

Failure to do so may impact your ability to participate in the Plan (including the Components).

### 1.7 When does participation end?

Participation in the Plan ends when you are no longer covered under any of the Components, regardless of the reason. In general, participation in any of the Components identified in Exhibit B continues until you elect not to participate, you are no longer an Eligible Employee, the Component terminates, you fail to make contributions in a timely manner, or your participation is terminated for cause. In most cases, benefit coverage ends on the last day of the month in which such an event occurs. However, different Components may have different "last day of coverage" rules depending upon the type of benefit and the reason for the cessation of participation. Furthermore, if you fail to make contributions in a timely manner, coverage may end on the last day of the last month for which you made the full contribution and there are other situations (e.g., fraud) in which coverage may be terminated retroactively (i.e., rescinded) when allowed by applicable law.

With respect to others who are covered through you, their coverage typically ceases if your coverage ceases. In addition, there may be other reasons that their coverage may end independently of whether your coverage ends (e.g., cease to meet the definition of dependent child).

### 1.8 How do I enroll and make benefit elections?

The Employer, in its capacity as Plan Administrator, will provide you with the forms necessary to enroll and make elections for the Components identified in Exhibit B, including information about the costs of the various Component benefits. For additional information regarding enrollment and benefit elections for a Component identified in Exhibit B, please read the information contained within the Exhibit applicable to the particular Component(s).

### 1.9 Can I change my election in a Component of the Plan during the Plan Year?

Whether a change in coverage under a particular Component can occur during the Plan Year depends upon the terms and conditions (1) of the Component, and (2) to the extent you pay for any portion of the cost of coverage on a pre-tax basis, the Employer's cafeteria plan under Section 125 of the Code (reflected in a separate document).

**Note**: If you are interested in making a change in coverage under a Component of this Plan, it is very important to check the Exhibit B Part relating to that Component. And, if you pay your share of the cost of coverage through the Employer's cafeteria plan, you need to check that plan's terms and conditions regarding changes during the Plan Year.

### 1.10 Must I make contributions to receive coverage and, if so, who holds the contributions I pay for a Component benefit?

The Employer may require you to pay all or a portion of the cost of coverage under a Component. If so, the Employer will notify you of the applicable contribution rates. Your required contributions (if any) may be made on a pre-tax basis if allowed under the Employer's cafeteria plan. If pre-tax contributions cannot be made through the cafeteria plan, you must make after-tax contributions. Such contributions are generally due by the first day of each month unless the Employer has agreed to another payment schedule, as identified in Exhibit A. A contribution grace period will be provided if one is required under applicable law or one is needed to ensure an offer of coverage has been made in accordance with Treas. Reg. § 54.4980H-3(g).

Your contributions towards the cost of coverage are held in the Employer's general assets. There is no separate trust. The contributions are held as part of the Employer's general assets until they are used to provide coverage under a Component (e.g., forwarded to the insurance carrier, used to pay benefits, etc.).

### 1.11 What happens when there is an insurance company refund?

Any refund provided to the Employer by an insurance company that has issued an insurance contract for any Component provided under the Plan will be allocated in accordance with the then prevailing United States Department of Labor (DOL) guidance. As a Participant in the Plan, you may directly benefit from such a refund. The portion of the refund allocated to Participants will be (i) used solely for the benefit of the Participants participating in the Component with respect to which the refund was provided, and (ii) returned to such Participants in a manner allowed by applicable law (e.g., to provide a refund, a premium holiday, an increase in benefits, etc.), as determined by the Plan. The portion of the refund allocated to Participants will be returned to the Participants no later than three (3) months following the date on which the Employer receives such refund from the insurance company.

### 1.12 What are the tax consequences to me?

Just because benefits are provided by your Employer under this Plan does not necessarily mean they are provided on a tax favored basis to you. Depending upon a variety of factors (including the type of benefit, the amount of the benefit, characteristics of the Eligible Employees and Participants, characteristics of those covered through Participants (e.g., children, spouse, etc.), etc.), the value of the benefit may or may not result in taxable wages to you.

### 1.13 Will I have any administrative costs under the Plan?

No. The entire cost of administering the Plan is paid by the Employer.

### 1.14 How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan (including each of the Components) indefinitely, the Employer has the right to amend or terminate the Plan in whole or in part at anytime. It is also possible that future changes in state or federal laws may require that the Plan be amended or terminated accordingly. You will be informed if changes are made to the Plan.

### 1.15 How are claims determined?

ERISA requires certain rules to be followed regarding the determination of claims for benefits (e.g., format, time frames, notifications, etc.). What rules apply in a particular situation depend upon a variety of factors (including the type of benefit, whether it is provided on an insured or self-insured basis, etc.). The underlying Plan document provides the overall structure for determining claims while many of the specifics of the particular Component are described in the Exhibit relating to that Component. It is intended that the claims procedures be in conformance with the applicable ERISA requirements.

**Special note regarding the Medical Plan Component**. With respect to the Drew University Medical Plan Component of the Plan, the Patient Protection and Affordable Care Act ("PPACA") also requires certain rules to be followed. The specifics of these rules and their application to the Medical Plan Component of the Plan are described in the Plan document and also in **Exhibit B-1. Affordable Care Act Compliance Policy** and its attachments for that Component (and subsequent changes to that Exhibit and its attachments). It is intended that the claims procedures be in conformance with the applicable PPACA requirements.

### 1.16 Can I assign my right to benefits under the Plan?

In general, benefits payable under the Plan (including any Component) cannot be assigned. However, with respect to particular Components, you may have limited rights to assign benefits to providers of health care services.

## PART II.
## CONTINUATION COVERAGE

### 2.1 What are my continuation rights under COBRA?

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires most employers to offer Employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where health coverage under an employer sponsored group health plan(s) would otherwise end. There is no requirement that a person be insurable to elect continuation coverage. However, a person who continues coverage may have to pay all of the premium for the continuation coverage. Medical, Dental, Vision, Health Flexible Spending Account (FSA) Benefits shall be operated consistent with COBRA and pursuant to COBRA policies and procedures contained in a separate document, which is incorporated by reference into the Plan and this SPD and is available to you upon request, at no charge.

### 2.2 What are my continuation rights under USERRA?

If you are called to active duty in the uniformed services, you may elect to continue coverage for you and your eligible dependents under Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") for a period of up to 24 months. You and your eligible dependents qualify for this extension if you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty (under a federal, not a state, call-up), the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States. This continuation right is similar to, and runs concurrent with, your continuation rights under COBRA (if any). The Medical, Dental, Vision, Health Flexible Spending Account (FSA) Benefits shall be operated consistent with USERRA and pursuant to USERRA policies and procedures contained in a separate document, which is incorporated by reference into the Plan and this SPD and is available to you upon request, at no charge.

### 2.3 What are my continuation and/or conversion rights for group health plan coverage under state law?

Some, but not all, states require continuation and/or conversion of group health insurance upon certain events. If provided under applicable state law, your continuation and/or conversion rights, and the rights of those who are covered through you, are described in the separate materials that have been provided to you either directly by the carrier (the insurance company) or by your Employer. If you have not been provided this information, you should contact the Employer.

## PART III.
## FAMILY AND MEDICAL LEAVE ACT OF 1993

### 3.1 Family and Medical Leave Act of 1993

The Family and Medical Leave Act of 1993 ("FMLA") imposes certain obligations on employers with fifty (50) or more Employees. In particular, the FMLA provides special protections for group health coverage. This Plan (including the Components) shall be administered in a manner consistent with the FMLA and the Employer's FMLA policy required thereunder which is incorporated by reference into the Plan and this SPD. If applicable to your situation, you will be provided with an explanation of your FMLA rights and responsibilities with respect to benefits under the Plan.

## PART IV.
## STATEMENT OF ERISA RIGHTS

As a Participant in this Plan (including any Components), you are entitled to certain rights and protections under ERISA.

**Receive Information About Your Plans and Benefits.** ERISA provides that all Participants shall be entitled to:

(a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) 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 summary plan description. The Plan Administrator may make a reasonable charge for the copies.

(c) 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 ("SAR").

**COBRA Rights.** As a Participant in the Plan, you are entitled to continue health coverage for yourself, your spouse or your dependents if there is a loss in coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

**Prudent Actions by Plan Fiduciaries**. In addition to creating rights for 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 Participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request 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 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 domestic relations order or 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

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.

**Very Important: Exhaustion of Administrative Procedures Required; Statute of Limitations.** The right to maintain a court action is subject to the Plan's requirements that administrative procedures be completed first. This is called exhaustion of administrative remedies. ***Failure to exhaust administrative procedures may preclude you from bringing an action in court***. Furthermore, if you intend to initiate legal action related to the Plan, including legal action for benefits under the Plan pursuant to Section 502(a) of ERISA, you must do so within two (2) years after receipt of a notification of an adverse benefit determination at the final level of appeal provided under the Plan. If, due to special circumstances, you were not required to exhaust your administrative remedies, legal action must be brought within two (2) years of the date the relevant claim for benefits was submitted to the Plan. You may not bring legal action after the expiration of the applicable limitations period. These deadlines for bringing a legal action apply unless a different time period is provided in Part of Exhibit B applicable to the Component with respect to which the action is being brought.

**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 or HIPAA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue 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.

## EXHIBIT A. Employer and Plan Information

### PART I. Employer Details

| | |
|---|---|
| **Employer and Plan Sponsor:** | Drew University<br>36 Madison Ave<br>Madison, NJ 07940<br>Phone: |
| **Employer Business Type:** | Corporation |
| **Employer Identification Number (EIN):** | 22-1487164 |
| **Employer subject to ERISA?** | Yes |
| **Commonly Controlled Entities:** | N/A |

### PART II. General Plan Information

| | |
|---|---|
| **Name of Plan:** | Drew University Health and Welfare Benefit Plan |
| **Plan Year:** | January 1 through December 31 |
| **Plan Number:** | 502 |
| **Effective Date of Plan:** | January 1, 2024 |
| **Original Effective Date of Plan:** | January 1, 2020 |
| **Type of Plan:** | The Plan provides comprehensive Medical, Dental, Vision, Group Life/AD&D, Long-Term Disability, Supplemental, Prepaid Legal, Health Savings Account (HSA), Health Flexible Spending Account (FSA) and Dependent Care FSA benefits and is considered a "Health and Welfare Benefit Plan" under ERISA. |
| **Plan Administrator:** | Drew University<br>Attn: Fredricka Cox<br>36 Madison Ave<br>Madison, NJ 07940<br>Phone: 973-408-3223 |
| **Agent for Service of Legal Process:** | Drew University<br>36 Madison Ave<br>Madison, NJ 07940<br>Phone: 973-408-3223<br><br>Legal process may also be served on the Plan Administrator. |
| **Named Fiduciary:** | Drew University |

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|---|---|
| | 36 Madison Ave<br>Madison, NJ 07940 |

**PART III. Additional Plan Details**

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|---|---|
| **COBRA Administrator:** | Clarity Benefits Solutions<br>77 Brant Ave<br>Clark, NJ 07066<br>Phone: 888-423-6359 |
| **Payperiod and Benefit Payment Frequency:** | Employee Class: Class 1<br><br>Pay Period: Bi-weekly<br><br>Employee Class: Class 2<br><br>Pay Period: Bi-weekly<br><br>Contributions/payments for benefits are taken at the same time as the applicable pay period for each employee class. |

## PART I. Carrier/Administrator Details

| Benefit Type | Policy Name | Insurer/Administrator | Policy Number/ Group ID | Claims Administrator | Funding | Policy/Plan Year |
|---|---|---|---|---|---|---|
| Medical | Liberty Direct HSA Plan OX NJLG | United HealthCare Oxford 170 Wood Ave. South 3rd Floor, Iselin, NJ, 08830 Phone: 800-666-1353 | 1412355 | Insurer/Carrier | Fully Insured | 1/1 - 12/31 |
| | Liberty EPO Low Plan NJ 30/50/100/80 | United HealthCare Oxford 170 Wood Ave. South 3rd Floor, Iselin, NJ, 08830 Phone: 800-666-1353 | 1412355 | Insurer/Carrier | Fully Insured | 1/1 - 12/31 |
| | Liberty Direct Freedom Mid Plan NJ 25/40/100/80 | United HealthCare Oxford 170 Wood Ave. South 3rd Floor, Iselin, NJ, 08830 Phone: 800-666-1353 | 1412355 | Insurer/Carrier | Fully Insured | 1/1 - 12/31 |
| | Liberty Classic Access High Plan NJ 15/30/100 | United HealthCare Oxford 170 Wood Ave. South 3rd Floor, Iselin, NJ, 08830 Phone: 800-666-1353 | 1412355 | Insurer/Carrier | Fully Insured | 1/1 - 12/31 |
| Dental | UHC Contributory Options PPO 30 High Plan | UnitedHealthcare Insurance Company 185 Asylum Street, Hartford, CT, 06103-0450 Phone: 860-702-5000 | 1412235 | Insurer/Carrier | Fully Insured | 1/1 - 12/31 |
| | UHC Contributory Options PPO 30 Medium Plan | UnitedHealthcare Insurance Company 185 Asylum Street, Hartford, CT, 06103-0450 Phone: 860-702-5000 | 1412235 | Insurer/Carrier | Fully Insured | 1/1 - 12/31 |
| | UHC Contributory Options PPO 30 Low Plan | UnitedHealthcare Insurance Company 185 Asylum Street, Hartford, CT, 06103-0450 Phone: 860-702-5000 | 1412235 | Insurer/Carrier | Fully Insured | 1/1 - 12/31 |
| Vision | Vision | Unum Life Insurance Company of America 2211 Congress Street, Portland, ME, 04122 Phone: 866-679-3054 Website: https://www.unum.com/ | 630803 | Insurer/Carrier | Fully Insured | 1/1 - 12/31 |
| Group Life/AD&D | Voluntary Life/AD&D | Unum Life Insurance Company of America 2211 Congress Street, Portland, ME, 04122 Phone: 866-679-3054 Website: https://www.unum.com/ | 630799 | Insurer/Carrier | Fully Insured | 1/1 - 12/31 |
| | Life & AD&D | Unum Life Insurance Company of America 2211 Congress Street, Portland, ME, 04122 Phone: 866-679-3054 Website: https://www.unum.com/ | 708643 | Insurer/Carrier | Fully Insured | 1/1 - 12/31 |

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|---|---|---|---|---|---|---|
| Long-Term Disability | Long Term Disability | Unum Life Insurance Company of America 2211 Congress Street, Portland, ME, 04122 Phone: 866-679-3054 Website: https://www.unum.com/ | 708643 | Insurer/Carrier | Fully Insured | 1/1 - 12/31 |
| Supplemental | Hospital Indemnity | Unum Life Insurance Company of America 2211 Congress Street, Portland, ME, 04122 Phone: 866-679-3054 Website: https://www.unum.com/ | 630800 | Insurer/Carrier | Fully Insured | 1/1 - 12/31 |
| | Critical Illness/Cancer | Unum Life Insurance Company of America 2211 Congress Street, Portland, ME, 04122 Phone: 866-679-3054 Website: https://www.unum.com/ | 630802 | Insurer/Carrier | Fully Insured | 1/1 - 12/31 |
| | Accident | Unum Life Insurance Company of America 2211 Congress Street, Portland, ME, 04122 Phone: 866-679-3054 Website: https://www.unum.com/ | 630801 | Insurer/Carrier | Fully Insured | 1/1 - 12/31 |
| Prepaid Legal | Legal Shield | Legal Shield<br><br>Phone: 800-699-7076 | See Component Benefit documents or contact plan Administrator | Insurer/Carrier | Fully Insured | 1/1 - 12/31 |
| Health Savings Account (HSA) | Health Savings Account (HSA) | Clarity Benefit Solutions 77 Brant Avenue Suite 206, Clark, NJ, 07066 Phone: 888-423-6359 | See Component Benefit documents or contact plan Administrator | Insurer/Carrier | | 1/1 - 12/31 |
| Health Flexible Spending Account (FSA) | Health Flexible Spending Account (FSA) | Clarity Benefit Solutions 77 Brant Avenue Suite 206, Clark, NJ, 07066 Phone: 888-423-6359 | See Component Benefit documents or contact plan Administrator | Insurer/Carrier | Self Insured | 1/1 - 12/31 |
| Dependent Care FSA | Dependent Care FSA | Clarity Benefit Solutions 77 Brant Avenue Suite 206, Clark, NJ, 07066 Phone: 888-423-6359 | See Component Benefit documents or contact plan Administrator | Insurer/Carrier | Self Insured | 1/1 - 12/31 |

## PART II. Specific Plan/Policy Information

| Benefit Type | Policy/Plan Name | Eligibility | Waiting Period | Coverage Ends | Spouse/Dependent Coverage (incl. Domestic Partners) | Employer Contribution | Premium Payment | COBRA | ERISA |
|---|---|---|---|---|---|---|---|---|---|
| Medical | Liberty Direct HSA Plan OX NJLG | Full Time employees working 30 hours per week | First of the month following 30 days after date of hire | Last day of the month in which eligibility ends | Legal Spouse and Dependent Child(ren) Registered Domestic Partner | Employer pays portion of premium | Pre-tax | Yes | Yes |
| | Liberty EPO Low Plan NJ 30/50/100/80 | Full Time employees working 30 hours per | First of the month following 30 days after | Last day of the month in which eligibility | Legal Spouse and Dependent Child(ren) Registered | Employer pays portion of premium | Pre-tax | Yes | Yes |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | week | date of hire | ends | Domestic Partner | | | | |
| | Liberty Direct Freedom Mid Plan NJ 25/40/100/ 80 | Full Time employees working 30 hours per week | First of the month following 30 days after date of hire | Last day of the month in which eligibility ends | Legal Spouse and Dependent Child(ren) Registered Domestic Partner | Employer pays portion of premium | Pre-tax | Yes | Yes |
| | Liberty Classic Access High Plan NJ 15/30/100 | Full Time employees working 30 hours per week | First of the month following 30 days after date of hire | Last day of the month in which eligibility ends | Legal Spouse and Dependent Child(ren) Registered Domestic Partner | Employer pays portion of premium | Pre-tax | Yes | Yes |
| Dental | UHC Contributor y Options PPO 30 High Plan | Full Time employees working 30 hours per week | First of the month following 30 days after date of hire | Last day of the month in which eligibility ends | Legal Spouse and Dependent Child(ren) Registered or Non-Registered Domestic Partner | Employer pays portion of premium | Pre-tax | Yes | Yes |
| | UHC Contributor y Options PPO 30 Medium Plan | Full Time employees working 30 hours per week | First of the month following 30 days after date of hire | Last day of the month in which eligibility ends | Legal Spouse and Dependent Child(ren) Registered or Non-Registered Domestic Partner | Employer pays portion of premium | Pre-tax | Yes | Yes |
| | UHC Contributor y Options PPO 30 Low Plan | Full Time employees working 30 hours per week | First of the month following 30 days after date of hire | Last day of the month in which eligibility ends | Legal Spouse and Dependent Child(ren) Registered or Non-Registered Domestic Partner | Employer pays portion of premium | Pre-tax | Yes | Yes |
| Vision | Vision | Full Time employees working 30 hours per week | First of the month following 30 days after date of hire | Last day of the month in which eligibility ends | Legal Spouse and Dependent Child(ren) Registered or Non-Registered Domestic Partner | Premiums are paid entirely by Employee payroll deductions | Pre-tax | Yes | Yes |
| Group Life/AD&D | Voluntary Life/AD&D | Full Time employees working 30 hours per week | First of the month following 30 days after date of hire | Other | Legal Spouse and Dependent Child(ren) Registered or Non-Registered Domestic Partner | Premiums are paid entirely by Employee payroll deductions | Pre-tax | No | Yes |
| | Life & AD&D | Full Time employees working 30 hours per week | First of the month following 30 days after date of hire | Other | No Spouse or Dependent Coverage Registered or Non-Registered Domestic Partner | Premiums paid entirely by Employer | Employer Paid | No | Yes |
| Long-Term Disability | Long Term Disability | Full Time employees working 30 hours per week | First of the month following 30 days after date of hire | Other | No Spouse or Dependent Coverage Registered or Non-Registered Domestic Partner | Premiums paid entirely by Employer | Employer Paid | No | Yes |
| Supplemental | Hospital Indemnity | Full Time employees working 30 hours per week | First of the month following 30 days after date of hire | Last day of employment | Legal Spouse and Dependent Child(ren) Registered or Non-Registered Domestic Partner | Premiums are paid entirely by Employee payroll deductions | Pre-tax | No | Yes |
| | Critical Illness/Cancer | Full Time employees working 30 hours per week | First of the month following 30 days after date of hire | Last day of employment | Legal Spouse and Dependent Child(ren) Registered or Non-Registered Domestic Partner | Premiums are paid entirely by Employee payroll deductions | Pre-tax | No | Yes |
| | Accident | Full Time employees working 30 hours per | First of the month following 30 days after | Last day of employment | Legal Spouse and Dependent Child(ren) Registered or | Premiums are paid entirely by Employee | Pre-tax | No | Yes |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | week | date of hire | | Non-Registered Domestic Partner | payroll deductions | | | |
| Prepaid Legal | Legal Shield | Full Time employees working 30 hours per week | First of the month following 30 days after date of hire | Last day of the month in which eligibility ends | Legal Spouse and Dependent Child(ren) Registered or Non-Registered Domestic Partner | Premiums are paid entirely by Employee payroll deductions | Pre-tax | No | Yes |
| Health Savings Account (HSA) | Health Savings Account (HSA) | Full Time employees working 30 hours per week | First of the month following 30 days after date of hire | Last day of the month in which eligibility ends | Legal Spouse and Dependent Child(ren) Registered or Non-Registered Domestic Partner | Premiums are paid entirely by Employee payroll deductions | Pre-tax | No | No |
| Health Flexible Spending Account (FSA) | Health Flexible Spending Account (FSA) | Full Time employees working 30 hours per week | First of the month following 30 days after date of hire | Last day of the month in which eligibility ends | Legal Spouse and Dependent Child(ren) Registered or Non-Registered Domestic Partner | Premiums are paid entirely by Employee payroll deductions | Pre-tax | Yes | Yes |
| Dependen t Care FSA | Dependent Care FSA | Full Time employees working 30 hours per week | First of the month following 30 days after date of hire | Last day of the month in which eligibility ends | Dependent Child(ren) Only Registered or Non-Registered Domestic Partner | Premiums are paid entirely by Employee payroll deductions | Pre-tax | No | No |

**PART III. Additional Plan/Policy Details**

| Benefit Type | Insurer/Administrator | Policy Name/Number |
|---|---|---|
| Health Flexible Spending Account (FSA) | Clarity Benefit Solutions | Health Flexible Spending Account (FSA) |

Claims for reimbursement of eligible expenses incurred during the Plan Year may be submitted after the close of the Plan Year or, if applicable, the Grace Period during a period time known as the Run-Out Period. A Run-Out Period may also allow terminated Employees to submit claims incurred during their time of employment for a period of time following the date of termination.

**FSA Run-Out Period for end of Plan Year**: 90 days

**FSA Run-Out Period for Terminated Employees:** 30 days

The Grace Period is the period of time beginning the day after the end of each Plan Year. Claims incurred during the Grace Period are considered to have been incurred during both the preceding Plan Year and the current Plan Year, and will be allocated to and reimbursed from the FSA for the preceding Plan Year until the account is exhausted.Afterward, claims will be allocated to and reimbursed from the FSA for the current Plan Year.

**FSA Grace Period**: 75 days

| Benefit Type | Insurer/Administrator | Policy Name/Number |
|---|---|---|
| Dependent Care FSA | Clarity Benefit Solutions | Dependent Care FSA |

Claims for reimbursement of eligible expenses incurred during the Plan Year may be submitted after the close of the Plan Year or, if applicable, the Grace Period during a period time known as the Run-Out Period. A Run-Out Period may also allow terminated Employees to submit claims incurred during their time of employment for a period of time following the date of termination.

**FSA Run-Out Period for end of Plan Year**: 90 days

**FSA Run-Out Period for Terminated Employees:** 30 days

The Grace Period is the period of time beginning the day after the end of each Plan Year. Claims incurred during the Grace Period are considered to have been incurred during both the preceding Plan Year and the current Plan Year, and will be allocated to and reimbursed from the FSA for the preceding Plan Year until the account is exhausted.Afterward, claims will be allocated to and reimbursed from the FSA for the current Plan Year.

**FSA Grace Period**: 75 Days

## Drew University Health and Welfare Benefit Plan

## Provisions under the Affordable Care Act

**Purpose.** The Purpose of this Affordable Care Act Compliance Policy ("ACA Compliance Policy") is to describe the methods established by the Employer, Drew University to remain compliant with the Affordable Care Act regulations regarding eligibility for health benefits.

The Patient Protection and Affordable Care Act ("PPACA" or "ACA") imposed rules for Applicable Large Employers ("ALE") that include, but are not limited to, definition and calculation of hours of service, classification of employees, eligibility determinations for health plans, and providing standards for plan affordability. The method(s) outlined in this policy apply specifically to benefit plans offering medical coverage.

**Special Definitions.**

(a) **Applicable Large Employer** means an employer that employed an average of at least 50 Full-Time Employees (including Non-Full-Time Employees ("Full-Time Equivalent" or "FTE") averaging at least 30 hours per week) during the preceding calendar year.
(b) **Employee** has the meaning set forth in the Plan.
(c) **Hour of Service** means (1) each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the company; (2) each hour for which an Employee is paid, or entitled to payment, by the Employer for a period of time during which no duties are performed (e.g., paid vacation, holiday, illness, disability, layoff, jury duty, military leave, paid leave of absence); and (3) each hour of unpaid leave that is subject to FMLA, USERRA, or on account of jury duty.
(d) **New Employee** means an Employee who was rehired after expiration of the parity period established for the plan.
(e) **Ongoing Employee** means an Employee who was rehired within the parity period established for the Plan.
(f) **Patient Protection and Affordable Care Act ("PPACA" or "ACA")** means the comprehensive health care reform law enacted on March 23, 2010, that provides numerous rights and protections making health coverage more accessible and affordable and imposes requirements on applicable Employers to offer affordable health coverage to Full Time Employees.
(g) **Special Unpaid Leave** means unpaid leave subject to the Family and Medical Leave Act OF 1993 (FMLA) or to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) or on account of jury duty.
(h) **Waiting Period** – the period of time that must pass before coverage for an Employee (or their dependent who is otherwise eligible to enroll in the Plan) becomes effective. The ACA prohibits waiting periods for New Employees for group health plan benefits that exceed 90 days.

**Rehired Employees.** The Employer has elected to implement the Rule of Parity to determine if a rehired Employee will be treated as a "new" Employee (i.e., Employee must complete the applicable waiting period to become eligible for benefits again) or an "ongoing" Employee (i.e., Employee is eligible for benefits upon rehire). This rule applies when an Employee has worked less than 13 weeks prior to their date of termination. An Employer may treat a rehired Employee with a break of at least 4 weeks (with no credited hours of service) as a New Employee if the break was longer than the Employee's period of service immediately preceding the break.