



BROWN UNIVERSITY

GROUP HEALTH AND GROUP DENTAL PLANS

Summary Plan Description

2008

SUMMARY PLAN DESCRIPTION (SPD)

THE BROWN UNIVERSITY GROUP HEALTH AND GROUP DENTAL PLANS

INTRODUCTION

Brown University sponsors the Group Health and Group Dental Plan under contracts with Blue Cross & Blue Shield of Rhode Island and UnitedHealthcare of New England, Inc. (“the health insurance companies”) and the Group Dental Plan under a contract for insurance with Delta Dental of Rhode Island. Hereinafter, the Group Health Plan and the Group Dental Plan will be referred to as “the Plan.”

The following documents are intended to provide you with a complete overview of your coverage and, combined, they constitute the Plan Document for the Group Health and Dental plans:

- (1) This general Summary Plan Description for all Health and Dental plans
- (2) The Blue Cross & Blue Shield of Rhode Island (BCBSRI) Benefit Booklets
- (3) The UnitedHealthcare of New England, Inc. (UHCNE) Summary Plan Description
- (4) The Delta Dental of Rhode Island (DDR) Certificate of Coverage (available at: www.deltadentalri.com)
- (5) The respective separate Provider Directory from each insurance company as revised from time to time

You will find the BCBSRI Benefit Booklet or the UHCNE Summary Plan Description for your employee group on-line at Health Insurance web page of Brown’s benefits website, while the DDR Plan Summary for each dental option offered by Brown University is available at the Dental Insurance web page.

Additionally, UHCNE will mail to you the appropriate Summary Plan Description for the Choice Plus plan at no cost upon your enrollment in the Plan. BCBSRI will mail to you the appropriate Benefit Booklet upon request. Updated copies of these materials and of the associated health insurance provider directory may be obtained at no cost from each insurance company respectively.

Provider directories for each plan are available upon request from each respective insurance company or on-line at the URLs listed below under General Plan Information.

This document contains information regarding Plan eligibility, enrollment, premium cost sharing arrangements, coverage and coverage changes, termination and continuation, and administrative procedures. The additional Plan Documents listed above include a description of covered services, plan benefits and the conditions under which benefits are available to insured individuals, as well as the procedures for applying for benefits and the appeals process for seeking a review of a benefit denial.

DEFINITIONS

Coinsurance [also see: copayment] – The set percentage share of the cost of office visits, prescriptions or treatments that you may pay for health care services. For example, if your health plan has an 80%/20% coinsurance arrangement, the plan will pay 80% of usual and customary expenses for health care services and you will pay coinsurance of 20%.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – If you terminate employment with the University or if you should become otherwise ineligible for health insurance coverage for reasons other than gross misconduct, you may elect to continue your (and your eligible dependents’) insurance coverage temporarily under the provisions of COBRA.

Contribution – Your payment toward the monthly cost of your insurance. Your contribution is generally pre-tax, which means that the contribution is deducted from your pay before taxes are calculated, allowing you to avoid paying taxes on that income. Post-tax contributions may be required in certain situations, or may be elected by selecting the post-tax “Contribution Method” option when you enroll; however, post-tax contributions will be taxed along with the rest of your pay.

Copayment [also see: coinsurance] – The flat dollar amount that you may pay for the cost of office visits, prescriptions, treatments or other health care services. For example, if you pay \$15 for an office visit and your health plan pays the rest, \$15 is your copayment.

Deductible [also: annual deductible, family deductible] – An amount you must pay before your insurance will begin to pay or reimburse you for covered services. Once you have paid your annual deductible, your insurance will pay for covered services at designated percentages.

Dependents – Generally, persons who rely upon you for primary support (including your spouse) or, if eligible according to a particular plan's definitions, those you designate to receive benefits from a given plan. While dependents are generally claimed as exemptions on tax returns, an individual need not be your tax dependent to be eligible for coverage under the Brown University Plan.

Fiduciary – Under the Employee Retirement Income Security Act of 1974 (ERISA), any person who exercises any discretionary authority or control over the management of a plan or the management or disposition of its assets, or who has any discretionary authority or responsibility in the administration of a plan; or, one who acts in a capacity of trust and who is therefore accountable for whatever actions may be construed by the courts as breaching that trust. Under ERISA, fiduciaries must discharge their duties solely in the interest of the participants and beneficiaries of an employee benefit plan.

Formulary – A drug formulary is a list of prescription drugs that a plan deems to be the most useful in patient care, based on clinical effectiveness and cost. A formulary may contain generic equivalent and brand-name drugs.

Fully Insured Plan – A plan under which an employer pays a fixed premium rate to the insurance company and the insurance company assumes all of the risk for the cost of providing benefits to the plan's enrollees. Fully Insured plans are non-participating, meaning that there are no deficits or refunds paid by the insurance company. The insurance company retains 100% of any profits or deficits realized under the fully insured program.

Generic Equivalent Drug – A generic equivalent drug is generally equal in therapeutic power to the brand-name original because it contains the same active ingredients at the same doses. The copayment for a generic equivalent drug is generally less than for a brand-name original, and generic equivalent drugs usually cost less than brand-name drugs.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) – HIPAA legislation requires group health and/or dental plans to offer a special enrollment period for employees and dependents who previously declined coverage without having to wait for the plan's next open enrollment period, subject to certain conditions. You and your eligible dependents may enroll in Brown University's group health plan if you lose other coverage because you exhaust COBRA coverage under another group plan, if you lose eligibility for the other plan, or if employer contributions for the other plan end.

You must notify the Benefits Office in writing and with supporting documentation within 31 calendar days of your loss of other coverage in order to be eligible for the special enrollment period. Please note that the HIPAA regulations allow you and your dependent to enroll, even if it is only your dependent who lost coverage.

Health Maintenance Organization (HMO) – This term is defined specifically in the Health Maintenance Act of 1973 as a legal entity or organized system of health care that provides directly or arranges for a comprehensive range of basic and supplemental health care services to a voluntarily enrolled population in a geographic area on a primarily prepaid and fixed periodic basis. An open access HMO operates without the common requirement of HMOs to funnel health care services through a primary care physician (i.e., an internist, family practitioner or pediatrician).

In-network [also: participating provider] – A group of doctors, dentists, pharmacies, hospitals, labs or other providers that are active participants in one of the health or dental insurance plans.

Inpatient services – Medical or other services received during a hospital stay of 24 hours or longer.

Lifetime maximum – The maximum amount that health insurance through Brown University will pay for you during your entire life. Under Brown's medical plans, if a lifetime maximum applies, it applies only to costs for out-of-network services. Refer to your Plan Documents for additional information.

Medically appropriate/necessary – An evaluation system used by health insurance companies to determine how vital a recommended health care procedure may be to your (or a dependent's) personal health. *In most cases, services determined to be medically unnecessary will not be covered, nor will you be reimbursed should you proceed to obtain such services.*

National Medical Support Notice (NMSN) – A standardized Qualified Medical Child Support Order (QMCSO) created by the U.S. Departments of Labor and Health and Human Services. An employer receiving a properly completed NMSN must provide coverage under its health plan for the child named in the NMSN.

Non-Formulary – Usually a name-brand prescription drug that is not deemed by a plan to be the most useful in patient care, based on clinical effectiveness and cost. Less expensive name-brand or generic drugs that are clinically equivalent are generally included in the formulary. Non-formulary drugs may still be covered under the plan, but may be subject to a higher copayment.

Open Access Health Maintenance Organization (HMO) – An HMO that does not require a referral from an internist, family practitioner or pediatrician before you can see a specialist, whether in-network or out-of-network. An open access HMO has residency requirements and different underlying contracts, but otherwise operates very much like a Preferred Provider Organization.

Outpatient services – Medical or other services generally not requiring an overnight stay.

Out-of-area coverage – Medical coverage provided beyond a health insurance plan's usual geographic service area, usually on an emergency basis only.

Out-of-network [also: nonparticipating provider] – Doctors, pharmacies, hospitals, labs or other service providers that are *not* active participants in your health insurance plan's network.

Out-of-pocket expense [also: out-of-pocket maximums] – The money you pay toward health services that is not reimbursed by insurance. Consult your Plan Documents to learn if copayments, coinsurance and deductibles are included in your annual out-of-pocket maximum.

Pre-certification [also: preauthorization] – The pretreatment approval required by insurers in certain situations to validate the medical necessity of specific medical procedures (see "Medically appropriate/necessary" above). In some cases, the provider offering the proposed treatment may also need to be pre-certified.

Pre-existing condition – A diagnosed and/or treated medical condition you already have when you enroll in an insurance plan. *None of Brown's health plans will exclude you from coverage due to a pre-existing condition.*

Preferred Provider Organization (PPO) – A Preferred Provider Organization (PPO) allows you to seek services from a network of participating providers (physicians, hospitals, labs, etc.) or from a doctor or other provider outside the network. Copayments and coinsurance are generally less if you use an in-network provider. When using in-network services, you can schedule appointments directly with any PPO network provider.

Qualified Medical Child Support Order (QMCSO) – A judgment, decree or order that (1) is issued by a court of competent jurisdiction pursuant to a state domestic relations law or community property law; (2) creates or recognizes the right of an alternate recipient to receive benefits under his or her parent's employer's group health plan; and (3) includes certain information relating to the participant and alternate recipient. A National Medical Support Notice (NMSN) is a QMCSO issued using a federally created document.

Self Insured Plan – A plan under which an employer pays a fixed administrative fee to the insurance company to administer the benefit program (claims processing, member services, etc). The employer retains all of the risk and pays for all claims as they are incurred, instead of paying a fixed premium to the carrier.

Subrogation – In employee benefit plans, the right of the insurance company to recover benefits paid to participants through legal suit, if the action causing the medical expenses was the fault of another individual. Generally, subrogation is the substitution of one person or entity for another in regard to a legal right, interest or obligation.

Usual and customary expenses [also: reasonable and customary] – The amount on which your reimbursement is based. Costs for services are averaged geographically by the Health Insurance Association of America (HIAA) and cost ranges for a variety of services are calculated for insurance company use in establishing the amounts companies will pay for services on your behalf.

Utilization Review – A method of systematically reviewing medical necessity and appropriateness of health care, appropriateness of the institution providing treatment, nature and scope of treatment and timeliness and appropriateness of discharge for purposes of benefit coverage decisions.

INFORMATION ABOUT ELIGIBILITY FOR COVERAGE

All faculty and staff on the regular payroll with a paid appointment of at least 4 ½ months in length are eligible to participate in the Plan. If you are eligible for coverage under the Plan, you may elect coverage for yourself and your eligible dependents. Eligible dependents include:

- Your spouse, common law spouse, or same-sex domestic partner;
- Your divorced spouse, if coverage is required under a divorce decree or court order, up until the time that either party remarries;
- Your children under age 19 (including natural, step and adopted children and children for whom you have been granted legal guardianship);
- Your children ages 19 or above who are:
 - Dependent students, as defined by the plan, until the earliest of the end of the calendar year in which they graduate or reach age 25; or
 - Unable to support themselves as a result of physical or mental disability;
- Children of your same-sex domestic partner (including natural, step and adopted children and children for whom your same-sex domestic partner has been granted legal guardianship).

To elect coverage for your common law spouse or same-sex domestic partner and his/her children, you will be required to submit information that certifies your relationship. To continue coverage for children between the ages of 19 and 25 who are dependent students, you must provide acceptable proof of their student status to the insurance company upon request, at least once annually. To continue coverage for dependent children ages 19 or above who are disabled, you must provide acceptable proof of their disability to the insurance company upon request, generally no more than once annually.

You may elect individual (employee-only), 2-person (employee plus one) or family coverage.

WHEN COVERAGE BECOMES EFFECTIVE

1. At Time of Hire into an Eligible Position

If you are hired into an eligible position on the first day or the first working day of the month, your coverage under the health insurance component of the Plan becomes effective on the first day of that month. If you are hired into an eligible position after the first working day of the month, your coverage under the health insurance component of the Plan becomes effective on the first day of the month following your date of hire. Your coverage under the dental insurance component of the Plan becomes effective on the first day of the month coinciding with or following 90 calendar days of employment. Coverage for your eligible dependents becomes effective on the date that your coverage begins.

For insurance to become effective on your first date of eligibility, you *must* elect to enroll yourself (and your dependents) in the Plan within 31 calendar days of your date of hire or appointment into an eligible position or you will lose your ability to enroll mid-year, absent a Qualifying Event as defined below in number 3.

2. At Open Enrollment

Once each year, usually in the Fall, you will be given the opportunity to make enrollment changes such as adding or dropping coverage and/or changing your insurance company, level of coverage, or contribution method (pre-tax or post-tax). Coverage changes for you and your dependents made during Open Enrollment will become effective January 1st of the next calendar year. For Open Enrollment coverage changes to become effective on January 1st, you *must* submit a completed enrollment form to the Benefits Office on or before the annual Open Enrollment deadline, as established from year to year.

3. At Other Times During the Year

You may change your enrollment status mid-year only under limited circumstances known as Qualifying Events under Section 125 of the Internal Revenue Code and/or under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Qualifying events are limited to:

- Change in marital status due to marriage, divorce or death of your spouse;
- Birth, adoption or death of, or acquisition of a new dependent;

- Change from full-time to part-time employment or vice versa for you or your spouse;
- Loss of other coverage because you or your dependent exhausted COBRA coverage under another group plan, loss of eligibility for the other plan, or if employer contributions under the other plan cease;
- When an employed family member changes a health insurance election in a plan sponsored by her/his employer;
- When compliance with certain family relations orders or decrees (e.g., a Qualified Medical Child Support Order) is legally required*;
- Change in employment status for you, your spouse or your covered dependent (including a strike or lockout, commencement or return from an unpaid Family/Medical or RI Parental and Family Medical Leave of Absence); or,
- When you or any of your covered dependents become entitled to or lose Medicare or Medicaid coverage.

**The insurance companies have procedures for the qualification and processing of a Medical Child Support Order and for processing a National Medical Support Notice. A copy of these procedures is available from the Plan Administrator or the insurance companies. Issues involving the qualified status of Qualified Medical Child Support Orders may be pursued in federal court.*

Please note that the return to student status for a dependent child between the ages of 19 and 25 is *not* a Qualifying Event allowing you to change your level of coverage.

As a result of the Special Enrollment Rights created by HIPAA, if you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 calendar days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 calendar days after the marriage, birth, adoption or placement for adoption.

Your divorced or legally separated spouse may remain a covered dependent under the Plan if a court order mandates that you continue his or her coverage. Thus, although divorce and legal separation are Qualifying Events, they will not result in a loss of coverage. Similarly, the Plan continues coverage for dependent student children between the ages of 19 and 25 until the December 31 of the year in which they cease to be students. However, should you divorce or legally separate from your spouse under a court order that does not require his or her continued coverage as your dependent, you must notify the Benefits Office within 60 calendar days of this Qualifying Event. In addition, you must notify the Benefits Office within 60 calendar days from your child's January 1st loss of eligibility for coverage under the Plan. In each of these Qualifying Events, your covered dependent will have Plan continuation rights described in [Information about Coverage Termination and Continuation Options](#) below. The required notice may be given by you or by a qualified covered dependent under your plan, and may be delivered in writing or in person to the Benefits Office, 164 Angell Street, 3rd floor, Box 1879, Providence, RI 02912-1879, by email to: Benefits_Office@Brown.edu, or by telephoning the Benefits Office at (401) 863-2141. You will be required to submit documentation, such as a court order, of a divorce or legal separation. For these Qualifying Events, and also for the loss of dependent child status, you must sign a Change of Status form and a Benefits Program Enrollment Form, which is obtainable at no cost from the Benefits Office or on-line at: http://www.brown.edu/Administration/Human_Resources/forms/index.html

You may add or drop coverage for yourself and/or your dependents as a result of a Qualifying Event, but you may *not* change insurance companies as a result of a mid-year Qualifying Event other than a HIPAA qualifying event. Changes made as a result of one of the Qualifying Events listed above must be consistent with the event (e.g., you may add but not drop coverage under this Plan because you lost coverage under another group plan).

If you have elected the post-tax contribution method (see Section below titled Cost of Coverage), you may drop coverage for yourself or add or drop a dependent from your existing coverage mid-year absent a Qualifying Event, but a Qualifying Event is required if you wish to add coverage for yourself mid-year.

Mid-year coverage changes made as a result of a Qualifying Event will become effective on the first of the month following the date of the Qualifying Event (with the exception of coverage changes to add a newborn or newly adopted child, which will become effective on the date of the birth or adoption). For insurance to become effective as a result of this change, you *must* elect to change enrollment for yourself and/or your dependents in the Plan within 31 calendar days of the Qualifying Event and you must provide supporting documentation to verify the Event.

If you experience a Qualifying Event and make coverage changes as described above, the coverage you had in place prior to the Qualifying Event will remain in effect until the last day of the month in which the Event occurred.

INFORMATION ABOUT PLAN BENEFITS

Benefits under the Plan are provided through a policy issued by Blue Cross & Blue Shield of RI, 444 Westminster Street, Providence, RI 02903, or UnitedHealthcare of New England, 475 Kilvert Street, Warwick, RI 02886, or by Delta Dental of RI, 10 Charles Street, Providence, RI 02904. The insurer is responsible for providing medical or dental services, claims payment and claims administration.

A detailed schedule of benefits, including the complete description of the benefits covered under the Plan, is contained in your Plan Documents, available at no cost to you.

The Plan Documents outline the cost-sharing provisions including deductibles, coinsurance, and copayment amounts for which you will be responsible; any annual or lifetime caps or other limits on benefits under the Plan; the extent to which preventive services are covered under the Plan; whether and under what circumstances existing and new drugs are covered under the Plan; whether and under what circumstances coverage is provided for medical tests, devices and procedures; provisions governing the use of network providers; the list of providers in the network, and whether and under what circumstances coverage is provided for out-of-network services; any conditions or limits on the selection of primary care providers or providers of specialty medical care; any conditions or limits applicable to obtaining emergency medical care; and, any provisions requiring pre-certification or utilization review as a condition to obtaining a benefit or service under the Plan.

In addition, the Plan Documents include a description of the procedures governing claims for benefits including (a) the procedure for obtaining pre-certifications, approvals, or utilization review decisions; (b) the procedure for filing claim forms, providing notifications of benefit determinations; and (c) the formal procedure for requesting review of denied claims, applicable time limits, and remedies available under the Plan for the redress of claims which are denied in whole or in part. They also describe each insurance company's subrogation process, or the process used by health insurance companies to recover expenses for services where a third party is legally responsible for a plan participant's injury or illness. Information about provider compensation or financial incentives offered by the insurance companies and about the methodology utilized to calculate copayments is available directly from each insurance company.

You may obtain a complete Provider Directory at no cost to you from the Benefits Office or the insurance companies at the phone numbers and URLs listed below under **General Plan Information**.

Certain plan benefits are mandated under federal law:

- **Newborns' and Mothers' Health Protection Act** – Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).
- **Women's Health and Cancer Rights Act: Special Rights Following Mastectomy** – Under this federal law, a group health plan must make certain benefits available to participants who have undergone a mastectomy that was covered by the Plan. In particular, a Plan must offer mastectomy patients benefits for:
 - Reconstruction of the breast on which the mastectomy has been performed;
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
 - Prostheses; and,
 - Treatment of physical complications of mastectomy.

Benefits for these items are comparable to those provided under the Plan for similar types of medical services and supplies. The extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient.

The Plan complies with these requirements and neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.

A plan that is subject to the Health Insurance Portability and Accountability Act (HIPAA) cannot discriminate on the basis of health factors. A plan cannot impose evidence of insurability or underwriting requirements, or otherwise determine eligibility for health coverage, on the basis of an individual's health status. The law prohibits discrimination among similarly situated plan participants and their dependents (including late enrollees) based on health status or health claims experience.

Under Rhode Island law, the Plan may not exclude coverage for pre-existing conditions. This means that if, prior to becoming covered under the Plan, you received medical consultation or treatment, or were diagnosed with a medical condition requiring continuing medical follow-up, all services offered in connection with that condition after your enrollment in the Plan will immediately be covered under the benefit schedule offered by the insurance company you elected.

INFORMATION ABOUT THE COST AND REQUIRED CONTRIBUTION FOR COVERAGE

Cost of Coverage

You are required to contribute toward the cost of the full monthly premium for the coverage options that you elect. Contribution levels may vary based upon your title, classification (union or non-union), and benefits percent (which generally correlates with percent time worked). Each year, at the beginning of the Open Enrollment period and in advance of the start of the Plan Year (i.e., January 1st), you will be notified of the available health and dental plan options for the coming Plan Year, and of the share of the full monthly premium that you will be required to contribute for each coverage option.

The University reserves the right to change its portion of the premium payment at any time. You will be informed at the time of enrollment how to calculate your required monthly contribution towards the cost of coverage, and will be advised of subsequent changes to the required contribution. Required monthly contributions will be spread across your regular number of paychecks each month. (Contributions for bargaining unit members and other employees paid on a weekly basis will be spread equally across the first four pay periods of each month.)

The insurance companies notify Brown University annually of premium adjustments that will be made for the coming Plan Year, which starts January 1. You will be informed of any resulting changes to the cost of Plan coverage. The announcement will generally mark the beginning of the annual Open Enrollment period during which you may make changes to your health or dental insurance company/option and/or level of coverage under the Plan(s).

Please note that, in addition to premium contributions, depending on the coverage you elect, you may have to pay a copayment and/or coinsurance for medical and/or dental services and prescription drugs, and you may have to satisfy a deductible. Your coinsurance and copayments for certain medical and/or dental services and/or for prescription drugs are listed in the Plan Documents and on your member identification card. Benefit limits, such as maximum visits covered per year for certain services, are detailed in the Plan Documents. These documents will be mailed to you free of charge; they are also available on-line at the URLs listed below under General Plan Information.

Contribution Method

At the time of your enrollment in the Plan, you may elect to make any required contributions on a pre-tax or post-tax basis. If you do not specifically make an election, contributions will be made on a pre-tax basis unless your visa type and/or appointment status preclude it. Under a pre-tax contribution method, you will reduce your salary for federal, state and FICA tax purposes but you will limit your ability to make mid-year enrollment changes absent a Qualifying Event (see above, **When Coverage Becomes Effective**).

Retirees and retiree spouses, employees with certain types of visas and appointments, and COBRA enrollees are required to contribute on a post-tax basis. Under IRS regulations, premium payments for coverage for same-sex domestic partners and/or their children must also be made on a post-tax basis unless these individuals meet the definition of dependent under federal tax law. In addition, IRS regulations mandate that University contributions for coverage provided for non-dependent same-sex domestic partners and/or their children be taxed as if they were income to the employee (i.e., as "imputed income"). Contributions for children covered under a Qualified Medical Child Support Order or a National Medical Support Notice may not be made on a pre-tax basis unless the child is your dependent under federal tax law. University contributions for non-dependent children covered under the Plan as a result of one of these orders will also be taxed as if they were income to you.

INFORMATION ABOUT COVERAGE TERMINATION AND CONTINUATION OPTIONS

Termination of Coverage

Your coverage under the Plan will end on the last day of the month in which your employment ends.

A reduction in your percent time and/or a change in your title or pay status will not result in a loss of coverage for you, although it may constitute a Qualifying Event if it changes the contribution requirement for your coverage. (See the Cost of Coverage section above.) Coverage terminations made as a result of a Qualifying Event will be effective on the last day of the month in which the Event occurred.

Coverage for your eligible dependent student children between the ages of 19 and 25 will end on the last day of the calendar year in which they graduate or cease to be a student.

Divorced or legally separated spouses remain eligible for coverage under the Plan until the earliest of the date specified in the court order or the date that either you or your former spouse remarries.

Continuation Options

1. Continuation Rights under USERRA

Under the Uniformed Service Employment and Reemployment Rights Act of 1994 (USERRA), you are eligible to retain your coverage under the Plan for up to 24 months after you are called to active military service.

2. Continuation Rights under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (a federal law commonly referred to as "COBRA"), you and your eligible dependents have an opportunity to continue coverage under the Plan in certain circumstances where your coverage would otherwise end.

COBRA continuation coverage is a continuation of Plan coverage, and is available as a separate right to each person who is a "qualified beneficiary" under the Plan. A qualified beneficiary is someone who will lose coverage under the Plan because of a COBRA qualifying event (as listed below in this section). Depending on the type of COBRA qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Although they are not qualified beneficiaries under COBRA regulations, Brown University offers same-sex domestic partners and their children up to 18 months of continuation coverage under the Plan if coverage is lost because of a qualifying event.

You may elect to continue the coverage you had in place immediately prior to your COBRA qualifying event (subject to residency requirements). You, your covered spouse and any covered dependent children may elect COBRA coverage even if any of you are also covered by another group health plan or Medicare (Part A, Part B, or both) at the time of the qualifying event. A spouse or dependent child is entitled to elect continuation coverage even if the covered employee is not eligible or does not elect continuation coverage.

You must elect COBRA continuation coverage within 60 days of the later of the date you would otherwise lose coverage or the date of the COBRA election notice to you. To elect COBRA coverage, you must complete and return an election notice to the group health plan's Third Party Administrator. Under the Plan, qualified beneficiaries who elect continuation coverage must pay for continuation coverage. Payment for the first month of COBRA continuation coverage must be received within 45 days of the date continuation coverage is elected.

COBRA continuation coverage is administered for the Plan by the Third Party Administrator listed below under **General Plan Information**. Election notices, premium payments, and other communication about extending or terminating continuation coverage must be submitted to the Third Party Administrator in writing or in the manner they otherwise specify.

a. COBRA Qualifying Events

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

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

If you are a retiree (or the spouse or dependent child of a retiree) covered under the Plan, you will become a qualified beneficiary if you should lose your coverage under the Plan because Brown University files for bankruptcy.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan should any of the following qualifying events occur:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separated from your spouse.

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

- (1) The employee dies;
- (2) The employee's hours of employment are reduced;
- (3) The employee's employment ends for any reason other than his or her gross misconduct;
- (4) The employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The child's eligibility for coverage under the plan as a "dependent child" ends.

b. Notification of COBRA Qualifying Events

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to Brown University, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 31 calendar days following the date coverage ends.

For the other qualifying events (divorce or legal separation of the employee, and spouse or a dependent child's losing eligibility for coverage as a dependent child), *you* must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 day after the qualifying event occurs. You must send this notice to: Benefits Office, Brown University, Box 1879, Providence, RI 02912. You may also hand-deliver a notice to the Benefits Office, 164 Angell Street third floor, Providence, RI, or deliver a notice via e-mail to Benefits_Office@Brown.edu. You must complete a Change in Status Form and/or Benefits Program Enrollment Form and provide documentation of the qualifying event (e.g., a court order confirming the divorce or legal separation of the employee and spouse or confirmation of a dependent child's loss of eligibility for coverage as a dependent child) including the date of the event.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

c. Duration of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. If you elect COBRA coverage, your coverage will be identical to coverage provided under the Plan to similarly situated employees and dependents. Your COBRA coverage will become effective on the date that coverage would otherwise have ended.

When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage may last for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, continuation coverage may last for up to 18 months. If you are receiving severance pay from the University, coverage during your severance pay period is

counted toward your total period of COBRA eligibility. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

1. Disability extension - If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, *for a total maximum of 29 months*. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Third Party Administrator listed below under **General Plan Information**. You must include a copy of the Social Security Administration's determination letter along with your name and Social Security Number and the names of anyone in your family for whom you wish to continue COBRA coverage for a total maximum of 29 months.
2. Second qualifying event extension - If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, *up to a maximum of 36 months*. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Third Party Administrator listed below under **General Plan Information**. You must include a copy of the former employee's death certificate or Medicare card, a court order concerning the former employee's divorce or legal separation, or documentation of the dependent child's loss of eligibility under the Plan as a dependent child.

d. Cost of COBRA Continuation Coverage

You must pay 102% of the full monthly Plan premium for COBRA continuation coverage. In addition, under Internal Revenue Code regulations, if the maximum continuation coverage period is extended to 29 months because of a disability, the required payment is 150% of the premium for all 11 months of the disability extension. Special cost sharing arrangements may be available for those electing COBRA continuation coverage as part of a severance agreement. Additional information is available from the Benefits Office.

e. Early Termination of COBRA Coverage

Your COBRA continuation coverage may be ended prior to the eligibility periods described above for the following reasons:

- The required premium for your COBRA continuation coverage is not paid within 30 days of the due date;
- *After* electing COBRA, you become covered under any other group health plan (as an employee or otherwise) that does not contain any exclusion or limitation for any pre-existing conditions that applies to you or a covered dependent (when prior creditable coverage is considered if required under federal law);
- *After* electing COBRA, you become *entitled* to Medicare (Part A, Part B, or both);
- Brown University no longer provides any group health insurance coverage to any employee; or
- You are determined to be no longer disabled by the Social Security Administration.

f. Conversion to a Non-Group Policy

If you continue COBRA coverage for the full continuation coverage period, without early termination, you must be given the option of enrolling in an individual, non-group plan if your health insurance companies offers one.

3. Alternative Continuation Coverage for Retirees and Their Spouses or Same-Sex Domestic Partners

An alternative to COBRA continuation coverage is available for certain Brown University retirees and their spouses, same-sex domestic partners and eligible dependents. For purposes of this alternative coverage, a retiree is a faculty or staff member separating from employment at the University between the ages of 55 and 65, with 10 years of service on the regular payroll. All regular cumulative service counts toward the 10 years requirement.

Eligible retirees who are covered under the Plan at the time of their retirement may elect to continue coverage under the Plan from the date of their retirement until the first day of the month in which they attain the age of 65. The cost for retiree continuation coverage is the full monthly premium for the Plan elected, less a monthly offset. In addition, spouses or same-sex domestic partners of eligible retirees may also elect to continue coverage under the Plan from the date of their spouse or partner's retirement until the first day of the month in which they attain the age of 65. The cost for spousal or same-sex domestic partner coverage is the full monthly premium for the Plan elected.

If you enroll in this alternative group health coverage, you will lose all rights to COBRA continuation coverage under the Plan, as well as your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when this alternative group health coverage ends.

You must elect to enroll in this alternative continuation coverage for yourself and your spouse or same-sex domestic partner as of the date that your coverage as an active employee would end. If you do not elect coverage at that time, you will lose the right to elect retiree coverage at a later date. If you elect retiree coverage and subsequently drop it, you will lose the right to elect retiree coverage at a later date.

INFORMATION ABOUT PLAN ADMINISTRATION

Privacy Protection

The Plan is subject to federal standards regarding the privacy of individuals' health information (HIPAA's "Privacy Rules") with respect to the health benefits it provides. Brown University's health insurance companies are also subject to the Privacy Rules.

Under the terms of the Privacy Rules, the Plan is excused from complying with almost all provisions of the Privacy Rules, however, the insurance companies are responsible for meeting the requirements of the Privacy Rules with respect to the benefits they provide under the Plan. Upon enrollment, you will receive a notice from the insurance companies advising you of these privacy practices and your rights under the Privacy Rules.

As the employer sponsoring the Plan, Brown University may receive information from the Plan for plan administration functions (including assisting employees with claims). The Plan is required by law to protect the privacy of certain health information that may reveal your identity, please see the attached Notice of Privacy Practices for Employees for more details. If you have any questions about the notice, please contact the Brown University Benefit Office at (401) 863-2141.

The Plan is prohibited under the Privacy Rules from retaliating against you for exercising your rights, or assisting others in connection with enforcing the Privacy Rules, including the right to complain to the Department of Health and Human Services if you believe a violation has occurred. The Plan is also prohibited from requiring you to waive your rights under the Privacy Rules as a condition of enrollment in, or payment of benefits under, the Plan.

Plan Continuation

The University intends to continue the Plan indefinitely, but reserves the right to eliminate benefits and terminate or change the Plan at any time. The University may also delegate any of its powers and duties with respect to the Plan, or amendments, to one or more officers or other employees of the University. Any such delegation shall be stated in writing. Any discontinuance or modification of the Plan cannot adversely affect valid claims for benefits incurred by participants prior to the date of discontinuance or modification. Those valid claims will be paid under the terms of the plan that were in place prior to the modification, amendment or termination. If the Plan is terminated or changed, the University will exercise good faith, apply standards of uniform application, and refrain from arbitrary action.

INFORMATION ABOUT YOUR RIGHTS UNDER ERISA

Statement of ERISA Rights

As a participant in Brown University's Group Health and/or Group Dental Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- **Receive Information about Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office 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 Benefit 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 summary plan description. The 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 (SAR).

- **Continue Group Health and Dental Coverage**

Continue health or dental coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- **Receive a certificate of creditable coverage**

Reduce or eliminate exclusionary periods of coverage from pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new plan.

- **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, your union, 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 application or 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 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 Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a 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 the court costs and legal fees. If you are successful, the court may order the person you have sued to pay those costs and fees. If you lose, the court may order you to pay those costs and fees if, for example, 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, 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 & Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 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.

General Plan Information

<i>Plan Name(s):</i>	Brown University Group Health Plan Brown University Group Dental Plan
<i>Name and Address of Employer:</i>	Brown University Box 1879 Providence, RI 02912
<i>Employer Identification Number:</i>	05-0258809
<i>Plan Number(s):</i>	Plan Number 504 – Blue Cross & Blue Shield of RI Plan Number 506 – UnitedHealthcare of New England, Inc. Plan Number 503 – Delta Dental of RI
<i>Plan Type:</i>	Welfare benefit group health and group dental plan
<i>Type of Plan Administration:</i>	The health insurance plans are self-funded, while the dental insurance plans are fully insured group plans. Medical and dental services, claims payment and administrative services are provided by: Blue Cross & Blue Shield of Rhode Island 444 Westminster Street Providence, RI 02903-3279 Customer Service Telephone Number: 401-459-5000 <i>URL:</i> http://www.bcbsri.com UnitedHealthcare of New England, Inc. 475 Kilvert Street Warwick, RI 02886-1392 Customer Service Telephone Number: 866-633-2446 <i>URL:</i> http://www.uhc.com Delta Dental of Rhode Island 10 Charles Street Providence, RI 02904 Customer Service Telephone Number: 800-843-3582 <i>URL:</i> http://www.deltadentalri.com
<i>Plan Year:</i>	January 1 to December 31
<i>Plan Administrator:</i>	Director of Benefits Brown University Box 1879 164 Angell Street Providence, RI 02912 Telephone number: 401-863-2141 Facsimile number: 401-863-3158

Agent for Service of Legal Process: For disputes arising under the Plan, service of legal process may be made to:

Peter J. McGinn
Tillinghast Licht Perkins Smith & Cohen, LLP
10 Weybosset Street
Providence, RI 02903
Telephone number: 401-456-1200
Service of legal process may also be made upon the Plan Administrator.

Third Party Administrator

Altus Benefit Administrators
10 Charles Street
Providence, RI 02904-2208
Telephone number: 800-371-7542
Facsimile number: 401-457-7266
URL: <http://www.altusbenefitadmin.com>

For disputes arising under the insured portions of the Plan, service of legal process may be made upon Blue Cross & Blue Shield of Rhode Island, UnitedHealthcare of New England, Inc. or Delta Dental of Rhode Island.

BROWN UNIVERSITY HEALTH CARE BENEFITS PLANS AMENDMENT THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan Documents are amended by adding the following to the Brown University Benefit Health Plans (the Plan):

Brown University Medical Reimbursement Plan administered by Altus Business Administrators Plan 507

Brown University Dental Plan administered by Delta Dental of Rhode Island Plan 503

Brown University Health Insurance Plans administered by:

Blue Cross Blue Shield of Rhode Island Plan 504

UnitedHealthcare of New England Plan 506

Under the Federal privacy regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plans are required to protect the confidentiality of Protected Health Information (PHI). The Plan will not use or disclose health information protected by HIPAA, except for treatment, payment, health plan operations (collectively known as "TPO"), as permitted or required by state and federal law, or to business associates to help administer the Plan. The Plan's uses may include, but are not limited to:

- Determining eligibility or coverage under the plan including coordination of benefits;
- Adjudicating claims on your behalf including billing and collection problems;
- Underwriting and other activities relating to the creation, renewal, amendment or replacement of a health plan contract;
- Placing a contract for reinsurance and obtaining payment under a reinsurance contract; and
- Business management and general administrative activities.

Further, the Plan will take reasonable steps to ensure that any use or disclosure is the minimum necessary to accomplish the task.

The Plan and Brown University are separate and independent legal entities, which may exchange information to coordinate your Plan coverage. In order to receive PHI from the Plan, Brown University agrees and shall certify to the Plan that it will:

- Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to Brown University with respect to such information;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Brown University;
- Notify the Plan of any improper use or disclosure of PHI of which it becomes aware;
- Make PHI available to an individual based on HIPAA's access requirements;
- Make PHI available for amendment and incorporate any changes to PHI based on HIPAA's amendment requirements;
- Make available the information required to provide an accounting of disclosures of PHI;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with HIPAA;
- Ensure adequate separation between the Plan and Plan Sponsor as required by HIPAA; and
- If feasible, return or destroy all PHI received from Plan that Brown University still maintains in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, Brown University will limit further uses and disclosures to those purposes that make the return or destruction infeasible.

Only the following employees under the control of Brown University may have access to PHI: Director of Benefits, Benefits Manager and Benefits Financial Manager. Such employees may only have access to, and use and disclose, PHI for purposes of the plan administrative functions described in this Plan document that Brown University performs for the group health plan. Brown University designates its Human Resources Department as the office responsible for resolving issues of noncompliance by persons described in this paragraph.