

SUFFOLK UNIVERSITY

Boston, MA

This information provides you with
a Summary Plan Description for the

SUFFOLK UNIVERSITY RETIREE HEALTH PLAN

Revised
January 2011

**The Plan Sponsor
is
SUFFOLK UNIVERSITY
8 Ashburton Place
Boston, MA 02108**

***SUMMARY PLAN DESCRIPTION
for the
Suffolk University Retiree Health Plan***

***Restated
January 2011***

This Plan Description together with the appropriate Plan Booklet, Schedule of Benefits and Prescription Drug Coverage brochure provide you a Summary Plan Description of Suffolk University's Retiree Health Plan. Harvard Pilgrim Health Care Medicare Enhance and/or Tufts Health Plan Medicare Preferred mailed the Plan Booklet, the Schedule of Benefits and the Prescription Drug Coverage brochure to you upon your enrollment in the Plan.

Information regarding Plan eligibility, enrollment, premium costs and administrative procedures is contained in this Plan Description. The Plan Booklet, the Schedule of Benefits and the Prescription Drug brochure include a description of covered services, plan benefits and the conditions under which benefits are available to insured individuals as well as the procedure for applying for benefits and for seeking review of denied benefits.

Who is Eligible for the Plan

If you meet the following criteria, you will be eligible for the retiree health plan upon retirement:

- continuously employed by the University/NESAD since prior to November 1, 1995;
- retire at the age of Medicare eligibility or over (presently age 65) with 15 or more years of service;
- are a titled faculty member (titled faculty are those who hold the rank of professor, associate professor, assistant professor or instructor) or are an employee who has worked in a position budgeted at a minimum of 30 hours per week for at least 15 years;
- or, are a retired employee with a phased retirement agreement.

To be eligible for the retiree coverage you must enroll in Medicare Parts A & B.

When Do You Become Eligible for the Plan

You are eligible for the Plan upon your retirement from the University provided that you satisfy the eligibility requirements as outlined in the Section, “Who is Eligible for the Plan.”

When do you Become Eligible for Coverage for Your Spouse/Dependents

Your spouse or certified domestic partner who is the age of Medicare eligibility (presently 65) or older when you retire may enter the Plan when you enter the Plan.

If your spouse or certified domestic partner is under the age of Medicare eligibility upon your retirement, s/he may remain in the regular group plan to the age of Medicare eligibility. At the age of Medicare eligibility, s/he may enroll in the Plan. Your spouse or certified domestic partner must enroll in Medicare Parts A and B to be eligible to enroll in the Plan.

If eligible dependents (other than your spouse and/or certified domestic partners), are enrolled in the University’s regular group health plan at your retirement, they may remain in that plan to age of ineligibility provided the premium is paid for them on a monthly basis.

If your spouse or certified domestic partner does not enter the Plan upon your retirement because of coverage under an active employer health plan, your spouse/certified domestic partner may enter the Plan provided entrance is within 30 days of losing active employer health coverage. The University will request confirmation of loss of coverage from the former employer.

How Do You Enroll in the Plan

Initial Eligibility

The Human Resources Office will provide you with enrollment information upon your notification to the University of your retirement. You must enroll in the Plan at your initial eligibility. If you do not enroll at initial eligibility, you will not be able to enroll at a later date.

Circumstances Under Which You May Change Enrollment

Once a year at open enrollment (generally in the fall for a January 1 effective date), you may change enrollment between carriers. You will be notified in advance of the open enrollment period.

You may add coverage for a new spouse should you remarry after retiring or for a certified domestic partner. The new spouse/domestic partner must be eligible for Medicare Parts A & B. The coverage must be added within 30 days of the date of marriage or certification. The coverage for the spouse/domestic partner will be dependent upon what is allowed under Medicare rules.

****Procedures for OMCSO or NMSN**

The University has procedures for qualification and processing of a Qualified Medical Child Support Order or for the processing of a National Medical Support Notice. You may obtain a copy of these procedures from the Human Resources Office.

No Plan Discrimination Due to Health Factors in Enrollment or Participation

A plan that is subject to 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.

When Coverage Terminates

Your coverage and your spouse/domestic partner's coverage continues indefinitely, but you may voluntarily withdraw at any time. If you withdraw from coverage, however, you will not be able to re-enroll in the Plan at a later date.

Your other dependents' coverage ends when they reach the age of ineligibility or for other reasons as described in the Summary Plan Description for the Suffolk University Health Plan.

Cost of the Plan

You and the University share the cost of the premium for the Plan. You will be informed at the time of enrollment of your required contribution to the Plan, and are advised of subsequent changes in the required contribution.

Periodically, generally near the end of the Plan Year, the insurer advises the University of premium adjustments that will be made for the coming year. You will be informed of any changes to the cost of the premium under the Plan, generally before the beginning of the Plan Year, which is January 1.

Under IRS regulations, University contributions for domestic partners and their dependent children are taxed to the employee through imputed income unless the domestic partner and/or the children are dependents of the employee under federal tax law.

Plan Benefits

A complete description of benefits covered under the Plan may be found in the Plan Booklet, in the Schedule of Benefits and in the Prescription Drug flyer. The Prescription Drug flyer outlines the outpatient prescription drug benefit, the circumstances under which drugs are covered and the process for reviewing inclusion or exclusion of new drugs as they enter the market.

The Plan Booklet and the Schedule of Benefits outline, amongst other benefits, cost sharing provisions (such as deductibles, coinsurance and copayment amounts for which you or your dependent will be responsible); any annual or lifetime caps or other limits on benefits under the Plan; the extent to which preventive services are covered; the circumstances under which coverage is provided for medical tests, devices and procedures; provisions governing the use of network providers, the composition of the provider 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; any provisions requiring preauthorization or utilization review as a condition to obtaining a benefit or service under the Plan; and any preexisting condition exclusion. In addition, the Plan Booklet describes the subrogation process. This is the means used by health plans to recover expenses for services where a third party is legally responsible for a Plan participant's injury or illness.

Certain plan benefits are mandated under federal law as follows:

**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.

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

Privacy Rules

The Plan is subject to federal standards regarding the privacy of individuals’ health information (the “Privacy Rules”) with respect to the health benefits it provides. All health benefits under the Plan, including the health benefits for which you are currently enrolled with Harvard Pilgrim Health Care are provided under insurance policies or similar agreements for HMO or PPO benefits. Like the Plan, Harvard Pilgrim Health Care is 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 because the University creates and receives only very limited information regarding individuals’ participation in and claims under the Plan. Instead, Harvard Pilgrim Health Care is responsible for meeting the requirements of the Privacy Rules with respect to the benefits it provides under the Plan. You will receive a notice from Harvard Pilgrim Health Care advising you of these privacy practices and your rights relative to Harvard Pilgrim Health Care under the Privacy Rules.

Neither the Plan nor the University is required to take steps to protect the privacy of your health information or otherwise comply with the Privacy Rules, with two exceptions.

- 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 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.

Applying for Benefits

The claim application process, if applicable, is described in the Plan Booklet.

A Formal Complaint of Denied Claims

The process to be used in appealing a denial of claims is outlined in the Plan Booklet.

Amendment and Termination of the Plan

While it is expected that this Plan will continue indefinitely, the Board of Trustees of Suffolk University reserves the right to amend, otherwise modify or terminate the Plan at any time. Any amendment, modification or termination of the plan will not adversely affect valid claims incurred prior to plan changes. Those valid claims will be paid under the terms of the Plan that were in place prior to the modification, amendment or termination.

Statement of ERISA Rights

As a participant in Suffolk University's Health 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

(1) Examine, without charge, at the Plan Administrator's office all Plan documents, and copies of all documents filed by the Plan with the US Department of Labor, such as detailed annual reports and Plan Descriptions.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Coverage

Continue health care 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, which outlines the rules governing your COBRA continuation coverage rights.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan Fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Prudent Actions by Plan Fiduciaries

ERISA sets forth the duties of the people who are responsible for the operation of this Plan. The people who operate the Plan have a duty to do so prudently and in the interest of you, the other Plan participants and beneficiaries. No one, including the employer, may discharge or otherwise discriminate against you in any way to prevent you from obtaining benefits to which you are entitled under the Plan or exercising your rights under ERISA.

Enforce Your Rights

If your application or claim for benefits under the Plan is denied in whole or in part, you must receive a written explanation of the reasons for the denial. You have the right to have the Plan Administrator review and reconsider denied applications or requests on eligibility, participation, or other aspects of the operation of the Plan and to have the insurer review and reconsider denied claims under the contract. You have a right to know why the claim was denied or ignored in whole or in part, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, you may take steps to enforce these rights. For example, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Administrator. If a claim for benefits 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 sued to pay those costs and fees. If you lose, the court may order you to pay those costs and fees, for example, if it finds the claim is frivolous.

Assistance with Your Questions

Contact the Plan Administrator if you have any questions about this Plan. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, US Department of Labor listed in your telephone directory, or the Division of Technical Assistance & Inquiries, Pension and Welfare Benefits Administration, US Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.

Additional Information

Plan Name: Suffolk University Retiree Health Plan

Employer (Plan Sponsor): Suffolk University
Address: 8 Ashburton Place
Boston, MA 02108
Telephone: (617) 573-8415

Employer Identification Number: 04-2133255

Plan Number: 601

Type of Plan: This is a welfare benefit health insurance plan

Administration: The plan is fully insured by Harvard Pilgrim Health Care at
1600 Crown Colony Drive
Quincy, MA 02169
Or by Tufts Health Plan
705 Mount Auburn Street
Watertown, Massachusetts 02472-1508

Plan Administrator Suffolk University
8 Ashburton Place
Boston, MA 02108
(617) 573-8415

Plan Year: January 1 to December 31

Service of Legal Process: For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator at the above address. For disputes arising under those portions of the Plan insured by Harvard Pilgrim Health Care, service of legal process may be made upon Harvard Pilgrim Health Care at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.