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SUMMARY PLAN DESCRIPTION
SYRACUSE UNIVERSITY MEDICAL BENEFITS PLAN

This Summary Plan Description ("SPD") is intended to provide you with an easily understandable description of the main provisions of the Syracuse University Medical Benefits Plan ("Plan"). To serve this purpose, the SPD cannot explain all of the details of the Plan. If there are any inconsistencies between this SPD and the Plan document, the Plan document will govern. There are also certain other documents and website pages regarding the Plan that have been approved by the Syracuse University Office of Human Resources ("Office of Human Resources") that provide additional information about the medical benefits, prescription drug benefits, and the faculty and staff assistance program ("FSAP") benefits that are available under the Plan ("Medical Documents", "Prescription Drug Documents" and "FSAP Documents"). The Medical Documents, Prescription Drug Documents and FSAP Documents are intended to be read with, and considered part of, this SPD and are listed in Section 4.1. If you have questions or would like to see, or obtain a copy of the Plan document, please contact the Office of Human Resources of Syracuse University ("University").

As is the case with all other employee benefit plans of the University (and as explained further in Section 1.11 of this SPD), the University reserves the right to amend or terminate the Plan at any time (including, but not limited to, its eligibility, contribution, and benefit provisions).

I. GENERAL INFORMATION

1.1 Plan Name and Effective Date. The full name of the Plan is the Syracuse University Medical Benefits Plan, which was last amended and restated as of July 1, 2015.

1.2 Plan Number. The Plan Number assigned to the Plan is 501.

1.3 Plan Administrator. The Plan Administrator is the Administrative Benefits Committee of the University. The Administrative Benefits Committee may be contacted at the address and telephone number given in Section 1.4. The Administrative Benefits Committee is the "named fiduciary" for the Plan, within the meaning of Section 402(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

The claims administrator for the medical benefits offered under the SUBlue, SUOrange and SUPro benefit options under the Plan is Excellus BlueCross Blue Shield:

<table>
<thead>
<tr>
<th>Claims Address:</th>
<th>Appeals Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellus BlueCross Blue Shield</td>
<td>Excellus Health Plan, Inc.</td>
</tr>
<tr>
<td>P.O. Box 21146</td>
<td>Attn: Advocacy Department</td>
</tr>
<tr>
<td>Eagan, MN 55121</td>
<td>P.O. Box 4717</td>
</tr>
<tr>
<td>800.493.0318 (TTY/TTD: 800.662.1220)</td>
<td>Syracuse, NY 13221</td>
</tr>
</tbody>
</table>

The claims administrator for the prescription drug benefits offered under the Plan is:

<table>
<thead>
<tr>
<th>OptumRx</th>
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</thead>
<tbody>
<tr>
<td>P.O. Box 3410</td>
</tr>
<tr>
<td>Lisle, IL 60532-8410</td>
</tr>
<tr>
<td>866.854.2945</td>
</tr>
</tbody>
</table>

The claims administrator for the faculty and staff assistance program benefits offered under the Plan is the University’s Administrative Benefits Committee.

1.4 Employer Information. The Employer that established the Plan is:

| Syracuse University |
| Skytop Office Building |
| Syracuse, New York 13244-5300 |
| 315.443.4042 |
| Employer Identification Number: #15-0532081 |

1.5 Plan Year. The Plan Year means the 12-month period that begins July 1 and ends June 30. The Plan’s fiscal records are maintained on the basis of this Plan Year.
1.6 **Agent for Service of Legal Process.** The Plan Administrator is the designated agent for service of legal process (see Section 1.3).

1.7 **Type of Plan and Eligibility.** This Plan is a welfare benefit plan, as defined under ERISA, which provides medical benefits, prescription drug benefits, and faculty and staff assistance program benefits described in Section 4.1 to “Participants” (as that term is defined in Section 3.1) and their “Qualifying Dependents” (as that term is defined in Section 3.2).

1.8 **Plan Contributions.** Medical benefits and prescription drug benefits under the Plan are provided through self-insured arrangements. Premiums for medical and prescription drug benefit coverages are shared by the University and the Participant, and are determined each year based on the total expense to provide the coverage. Information about contribution rates has been provided to you by the Office of Human Resources. Failure to pay required premiums may result in loss of Plan coverage.

Faculty and staff assistance program benefits are also provided under a self-insured arrangement. “Benefits Eligible Employees” (as that term is defined in Section 3.1) are not currently required to contribute towards the cost of faculty and staff assistance program benefits.

See Section 4.2 for a further explanation of contribution requirements under the Plan.

1.9 **Discretion of Plan Administrator.** Notwithstanding any other provision in the Plan and this SPD to the contrary, and to the full extent permitted by law, the Plan Administrator (or its designees) shall have the discretionary authority to construe any uncertain or disputed term or provision in the Plan, this SPD and/or any related documents, and to decide all questions concerning the Plan and its application. The Plan Administrator’s exercise of this discretionary authority shall be binding upon all interested parties, including, but not limited to, the participant, participant's estate, any beneficiary of the participant and the University, and shall be given deference on any judicial (or other) review, to the fullest extent permitted by law.

1.10 **COBRA Continuation Coverage.** Under a federal law referred to as COBRA, “Qualifying Beneficiaries” (as that term is defined in section 6.2), have the right, at their own expense, to continue coverage that otherwise would end for the benefits described in Section 4.1. These rules, which are very important for you, are explained in Section 6.2 of this SPD and in the Medical Documents and Prescription Drug Documents. You may have other continuation coverage rights under state law. You should contact the University’s Office of Human Resources for further information.

1.11 **Right to Amend and Terminate Plan.** The University expressly reserves the unqualified right to amend or terminate the Plan at any time and for any reason, including, but not limited to, the right to change any benefit provisions and any required premium contributions, and member cost-sharing requirements, such as coinsurance, co-payments, and deductibles. Notwithstanding any other provision in the Plan or this SPD to the contrary, no Participant, Qualifying Dependent, or other beneficiary shall have any right to benefits under the Plan or SPD which in any way interferes with the University's right to terminate the Plan or amend the Plan. There are no contractual rights to benefits under the Plan. The University makes no promise to continue Plan benefits in the future, and rights to future benefits do not vest. In particular, termination of employment or retirement does not in any manner confer upon any Participant, Qualifying Dependent, or other beneficiary any irrevocable right to continued benefits under the Plan (other than the statutory continuation coverage rights for a limited period that are described in Section 1.10).

1.12 **Type of Administration.** Excellus BlueCross BlueShield is responsible for certain administrative functions relating to medical benefit coverage under the Plan, including the determination of claims for medical benefits and the payment of medical benefit claims. OptumRx is responsible for certain administrative functions relating to prescription drug benefit coverage under the Plan, including the determination of claims for prescription drug benefits and payment of prescription drug benefit claims.

The Administrative Benefits Committee is responsible for certain administrative functions relating to faculty and staff assistance program coverage under the Plan, including the determination of claims for faculty and staff assistance program benefits and the payment of faculty and staff assistance program benefits claims.

1.13 **Provider “Discounts.”** If any contracts with Plan benefit providers allow discounts, allowances, incentives, adjustments and/or settlements (collectively, “Discounts”), such Discounts are for the sole benefit of the Plan and the Plan will retain any payments resulting from the Discounts. All claims submitted to the Plan will have any co-payment, coinsurance, deductible, and out-of-pocket amounts calculated according to the providers’ charges for covered services or supplies without regard to the Discounts.
1.14 **Information to be Furnished.** You are required to provide the Plan Administrator and its designee(s) with such information and evidence, and to sign such documents, as may reasonably be requested from time to time for the purpose of Plan administration. If not so provided or signed, the Plan Administrator or its designee(s) may deny benefits until the requested information, evidence, and/or documents is/are furnished. If any false or misleading information concerning the Plan or any Plan benefit is provided to the Plan Administrator or its designee(s) by the Participant or a Qualifying Dependent (collectively, “Covered Person”), or any person or entity acting on behalf of a Covered Person, the Plan Administrator (or, if applicable, a designee of the Plan Administrator) will have the discretionary authority, to the full extent permitted by law, to terminate the coverage of the Covered Person prospectively and to recoup, offset or otherwise recover any overpayment or other benefit that the Covered Person received as a result of such false or misleading information. In the case of fraud or an intentional misrepresentation of material fact made by a Covered Person, the Plan Administrator or its designee reserves the right to terminate a Covered Person’s coverage retroactively, to the extent permitted by law, and to recoup, offset or otherwise recover any overpayment or other benefit that the Covered Person received as a result of such fraudulent act or intentional misrepresentation.

II. OVERVIEW OF PLAN

2.1 **Overview of Plan**

The Plan provides medical benefits, prescription drug benefits and faculty and staff assistance program benefits to Participants and their Qualifying Dependents.

If you are an eligible individual, you can enroll for coverage under the Plan if you:

(a) satisfy the eligibility requirements set forth in Article III below; and

(b) with respect to medical and prescription drug benefits, pay any amounts required.

Eligible individuals can enroll themselves and their Qualifying Dependents for medical and prescription drug benefit coverage under the Plan upon satisfying the specified eligibility requirements and/or during the Plan’s open enrollment period. If you do not enroll in the Plan within 31 days after you are first eligible, you and your Qualifying Dependents will have to wait until the Plan’s next open enrollment period to enroll for coverage (such coverage will be effective as of the January 1st that follows the open enrollment period); provided, however, that if federal law requires an earlier special enrollment period, such earlier special enrollment period will apply.

Benefits Eligible Employees and Qualifying Dependents of Benefits Eligible Employees are automatically enrolled for faculty and staff assistance program benefits upon satisfying the specified eligibility requirements.

Eligibility for Plan coverage will end on the date specified in Section 6.1.

III. ELIGIBILITY

3.1 **Eligibility Requirements for Participants**

You are eligible to become a Participant in the Plan if you (i) pay the amounts required by the Plan Administrator, (ii) satisfy all applicable Plan requirements (including any additional requirements that may be set forth in the Medical Documents and Prescription Drug Documents described in Section 4.1(b) of the SPD), and (iii) are classified in one of the following categories:

(a) **Benefits Eligible Employee:** A “Benefits Eligible Employee” of the University means an individual who has satisfied the requirements to be a “Benefits Eligible Employee” as that term is defined in the Syracuse University Benefits Eligibility Policy (“Benefits Eligibility Policy”) maintained by the Office of Human Resources and published on the University’s website (http://supolicies.syr.edu/emp_ben/benefits_eligible.htm). The Benefits Eligibility Policy is hereby incorporated by reference, and made a part of this SPD.

(b) **Employees of Drumlins Inc. (‘‘Drumlins’’):** An employee of Drumlins who is regularly scheduled to work at least 20 hours per week for at least 48 weeks of the calendar year, and who is classified as being eligible for Plan medical and prescription drug benefits in the records of the Office of Human Resources.
In addition to the requirements in subsections (a) and (b) above, any individual described above who is represented for collective bargaining purposes by a labor union will only be covered by the Plan to the extent Plan benefits have been agreed to by the applicable union and the University.

You are not eligible to participate in the Plan if you are an employee of the Syracuse University Hotel and Conference Center, LLC or S.U. Theatre Corporation (an exception exists if you also are employed by the University, are receiving compensation through the University’s Syracuse, New York payroll system, and satisfy certain other Plan requirements).

3.2 Eligibility Requirements for Qualifying Dependents

Your eligible spouse, eligible domestic partner, and eligible dependents (collectively, “Qualifying Dependents”) will be eligible for coverage under the Plan if the Qualifying Dependent meets the requirements to be an Eligible Spouse, Eligible Domestic Partner, or Eligible Dependent as defined in the Benefits Eligibility Policy maintained by the Office of Human Resources and published on the University’s website (http://supolicies.syr.edu/emp_ben/benefits_eligible.htm), or in accordance with the terms of the Plan if the relationship is with an individual identified in subsection 3.1 (b).

If a new Qualifying Dependent is not enrolled by you within 31 days after first being eligible, the Qualifying Dependent will not be eligible to be enrolled in the Plan again for coverage until the next open enrollment period for coverage under the Plan (with the following January 1st as the effective date of such coverage); provided, however, that if federal law requires an earlier special enrollment period, such earlier special enrollment period will apply. A description of the Plan’s special enrollment rules is set forth in the Benefits Eligibility Policy.

The eligibility of your Qualifying Dependents for Plan coverage will end on the date specified in Section 6.1.

3.3 Commencement of Participation

If you satisfy the eligibility requirements in Section 3.1 above you and your Qualifying Dependents can participate in the medical and prescription drug benefits offered under the Plan as of your first day of employment, provided you enroll in Plan coverage within 31 days after you are first eligible.

Thereafter, you may enroll yourself and your Qualifying Dependent(s) in the medical and prescription drug benefits offered under the Plan during an annual open enrollment period or during the 31 day special enrollment period following a qualifying life event, as described in the Benefits Eligibility Policy.

Benefits Eligible Employees and Qualifying Dependents of Benefits Eligible Employees are automatically enrolled in the faculty and staff assistance program benefits once they satisfy the eligibility requirements.

IV. BENEFIT OPTIONS

4.1 Benefit Coverage Options

(a) Coverage Options:

(i) Medical Benefits. The medical benefit coverage options provided under the Plan are SUBlue, SUOrange or SUPro (or if applicable, any successor options approved by the University from time to time).

(ii) Prescription Drug Benefits. The prescription drug coverage provided under the Plan is set forth in the Prescription Drug Documents specified by the Office of Human Resources.

(iii) FSAP Benefits. The FSAP benefits under the Plan are set forth in the FSAP Documents that are specified by the Office of Human Resources.

(b) Medical Documents, Prescription Drug Documents and FSAP Documents. The University offers medical, prescription drug and faculty and staff assistance program benefits through the Plan, in accordance with the terms of the Plan. Benefit and related provisions will be determined by the terms of the Medical Documents, Prescription Drug Documents and the FSAP Documents (which are incorporated by reference and made a part of the Plan) and by the other terms of the Plan. To the extent there are any inconsistencies between the Plan and this SPD, the
provisions of the Plan will govern. The Medical Documents, Prescription Drug Documents and the FSAP Documents listed below are hereby incorporated by reference and made a part of this SPD.

(i) Medical Documents:

(A) A medical booklet entitled:

SYRACUSE UNIVERSITY MEDICAL BENEFITS
SUBLUE
SUORANGE
SUPRO

(B) University documents provided annually entitled “SUBlue and SUOrange: Schedule of Benefits” and “SUPro: Schedule of Benefits”.

(C) A University document entitled “Syracuse University Benefits Eligibility Policy.”

(D) Any other document(s) or website pages specified by the Office of Human Resources.

(ii) Prescription Drug Documents:

(A) The documents that are used by the University’s prescription drug claims administrator to provide benefits under the Plan, and that have been approved by the Office of Human Resources.

(B) Any group contract, other written contract, or certificate between the University’s prescription drug claims administrator and the University, regarding prescription drug benefits under the Plan, exclusions of certain prescription drug benefits, eligibility for prescription drug benefits under the Plan, effective dates of prescription drug coverage and termination of prescription drug coverage under the Plan, and/or related Plan provisions concerning prescription drug benefits.

(C) A University document entitled “Syracuse University Benefits Eligibility Policy.”

(D) A medical booklet entitled:

SYRACUSE UNIVERSITY MEDICAL BENEFITS
SUBLUE
SUORANGE
SUPRO

(E) University documents provided annually entitled “SUBlue and SUOrange: Schedule of Benefits” and “SUPro: Schedule of Benefits”.

(F) OptumRx online formulary.

(G) Any other document(s) or website pages specified by the Office of Human Resources.

(ii) FSAP Documents:

(A) The FSAP pamphlets and other documents that are used with respect to FSAP benefits under the Plan, and that have been approved by the Office of Human Resources.

(B) Any group contract, other written contract, or certificate regarding FSAP benefits under the Plan, FSAP eligibility under the Plan, effective dates of FSAP coverage and termination of FSAP coverage under the Plan, and related FSAP provisions.

(C) A University document entitled “Syracuse University Benefits Eligibility Policy.”

(D) Any other document(s) or website pages specified by the Office of Human Resources.
4.2 Contribution Requirements

As discussed briefly in Section 1.8, Participants are required to contribute towards the cost of medical and prescription drug benefits provided under the Plan. Participants currently are not required to make any contributions toward the cost of faculty and staff assistance program benefits provided under the Plan.

The cost of coverage will be communicated to Participants upon eligibility and prior to the beginning of each annual open enrollment period, and can also be obtained from the Office of Human Resources. In the event of a cost change that occurs in the middle of a Plan Year, you will receive advance notice of the change. All correspondence regarding rates of contributions for coverage under the Plan is hereby incorporated by reference, and made a part of this SPD.

Information about other cost sharing requirements is set forth in the Medical Documents and the Prescription Drug Documents.

4.3 Coordination of Benefits

Medical coverage provided by this Plan is coordinated with coverage available under another medical benefits program. The purpose of coordination of benefits is to avoid both programs paying medical benefits for the same services. When an individual has medical coverage under this Plan and another medical plan, the individual has “primary” and “secondary” coverage. The program that is required to pay its benefits first is considered “primary.” The program that pays its benefits second is considered “secondary.” Any coordination of benefits with respect to the Plan will be done in accordance with: (a) any applicable Medical Document(s); and (b) any other requirements that may be specified by the Office of Human Resources from time to time. There is no coordination of benefits under the Plan with respect to the prescription drug and FSAP benefits.

V. CLAIMS FOR BENEFITS

A claim for medical benefits or prescription drug benefits under the Plan can be filed by an enrolled Plan Participant or Qualifying Dependent (a “claimant”), or by an authorized representative acting on behalf of a claimant, in the manner specified in the Medical Documents, Prescription Drug Documents, or any other document(s) that may be specified by the Office of Human Resources from time to time, as applicable.

A claim for FSAP benefits can be filed by a claimant or his or her representative. The claims procedures specified in the Medical Documents will generally apply to such claims, except that: (a) all administrative functions described in the procedures will be performed by the Plan Administrator; and (b) all claims, appeals and related documentation must be sent to the Plan Administrator identified in Section 1.3.

Please contact the Office of Human Resources if you have questions regarding the Plan’s claims procedures.

VI. TERMINATION OF COVERAGE

6.1 Termination of Coverage

There is no contractual right to benefits under this plan and future benefits will never vest. In particular, retirement does not in any manner confer upon you or your Qualifying Dependents any right to continued benefits under this Plan or any benefit options offered through the Plan, other than those specifically mentioned.

Generally, your participation in the Plan will end on the earlier of the date on which: (a) the Plan terminates; (b) you cease to be eligible to participate in the Plan; (c) you fail to pay any required premiums, or any costs specified by the Office of Human Resources; or (d) the date otherwise provided under the terms of the Plan.

Generally, your Qualifying Dependent will cease to be covered under the Plan as of the earliest of the following dates: (i) the date the Plan is terminated; (ii) the date your coverage under the Plan terminates; (iii) the date your Qualifying Dependent ceases to be eligible to be covered by the Plan; (iv) the date your Qualifying Dependent fails to pay any costs specified by the Office of Human Resources; or (v) the date otherwise provided under the terms of the Plan.
However, continued health coverage may be available for you, your covered spouse or covered domestic partner and covered dependents ("Qualified Beneficiaries") at your (or their) own expense. See Section 6.2 regarding continuation rights under the Plan.

Additionally, if you die while covered under the Plan, your Qualifying Dependents may be eligible for a limited period of additional Plan coverage after your death if permitted by the Office of Human Resources. Please contact the Office of Human Resources for additional information if you have any questions regarding such coverage.

6.2 COBRA Continuation Coverage

The term “COBRA” refers to the Consolidated Omnibus Budget Reconciliation Act of 1985. Under COBRA and the terms of the Plan, you, your covered spouse or covered domestic partner, and your covered dependents (collectively referred to as “Qualified Beneficiaries”) have the right to continue health coverage under the Plan in certain circumstances where such coverage would otherwise terminate.

An explanation of the COBRA provisions that apply to the medical, prescription drug and FSAP benefits offered under the Plan is set forth in the Medical and Prescription Drug Documents.

VII. ERISA RIGHTS

7.1 ERISA Rights

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

*Receive Information About Your Plan and Benefits*

This includes the ability to:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites, all documents governing the Plan, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, and copies of the latest annual report (Form 5500 Series) and updated SPD. The administrator may request a reasonable charge for the copies.

*Continue Group Health Plan Coverage*

You may have a right to continue health care coverage for yourself, your covered spouse or covered domestic partner, or your covered 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 SPD and the documents governing the Plan on the rules governing your COBRA and Plan continuation coverage rights.

*Prudent Actions by Plan Fiduciaries*

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, or any other person, may 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 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, 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 publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

VIII. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under this federal law, sometimes referred to as the "NMHPA," certain requirements are imposed on group health plans that provide maternity or newborn infant coverage. This includes the fact that the group health plans and health insurance issuers (such as insurance companies and HMOs) may not 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 caesarean section.

However, the NMHPA 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 issuer for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable.

IX. WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under this federal law, group health plans that provide medical and surgical benefits for mastectomies must provide coverage in connection with the mastectomy, in the manner determined by the attending physician and the patient, for: (i) reconstruction of the breast on which the mastectomy was performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (iii) prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema.

Group health plans and health insurers may not deny eligibility to enroll, renew or continue group health plan coverage to avoid providing coverage for breast reconstruction or mastectomy complications. Further, the law prohibits: (i) penalizing or otherwise reducing or limiting the reimbursement of an attending provider for the required care; or (ii) providing any incentive (monetary or otherwise) to induce the attending provider to provide care that would be inconsistent with the law. The above-described coverage required by the law may only be subject to the annual deductibles and coinsurance provisions that apply to similar benefits.
X. QUALIFIED MEDICAL CHILD SUPPORT ORDERS/ NATIONAL MEDICAL SUPPORT NOTICES

The Plan provides medical and prescription drug benefits in accordance with the applicable requirements of any "qualified medical child support order," or National Medical Support Notices, as required under ERISA. In general, the term "qualified medical child support order" means a "medical child support order" which requires the Plan to provide a child of a Participant with health coverage under the Plan where the child would not otherwise be covered (for instance, as a result of a parent's divorce). Contact the Plan Administrator if you have questions, or would like to obtain, without charge, a copy of the Plan’s procedures.

XI. OTHER LEGAL RULES

The Plan will be administered in accordance with the requirements of the following statutes: (a) the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"); (b) the Family and Medical Leave Act of 1993; (c) the Mental Health Parity Act of 1996; (d) the Paul Wellstone and Pete Domenici Mental Health Parity and Equity Addiction Act of 2008; (e) Michelle’s Law; (f) the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"); and (g) the Patient Protection and Affordable Care Act of 2010. Please contact the Office of Human Resources if you have any questions regarding these requirements.

HIPAA Non-Discrimination Rules: This Plan will not deny group health benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or medical condition (including both physical and mental health conditions). For example, the group health benefits will not exclude coverage for self-inflicted injuries due to a suicide attempt by a person who suffers from depression.

HIPAA Privacy Rules: This Plan will protect individually identifiable health information as required by the “Administrative Simplification” provisions of the HIPAA regulations. A copy of the Plan’s Notice of Privacy Practices ("NPP") has been provided to you. You can obtain a copy of the University’s HIPAA Privacy Policy, or a copy of the NPP from the Office of Human Resources.

In addition to the legal rules described above, the Plan will be administered in accordance with the requirements of all other applicable statutes and regulations. Pertinent legal requirements not addressed in this SPD are described in the Medical Documents, Prescription Drug Documents and FSAP Documents.