UNIVERSITY OF NEW ENGLAND
EMPLOYEE BENEFIT PLAN

PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION

Plan Administrator: University of New England
11 Hills Beach Road
Biddeford, ME 04005
207-602-2394

Agent for Service of Legal Process: University of New England
11 Hills Beach Road
Biddeford, ME 04005
Service may be made upon the plan administrator.

The details about pre-tax contributions are described in the University of New England Flexible Benefit Plan.

For Benefits that require enrollment, newly Eligible Employees must generally enroll within certain time periods after being hired or first becoming eligible, as described in the University of New England Flexible Benefit Plan and the Benefit documents. Thereafter, enrollment is generally limited to the annual open enrollment period that occurs before the start of each year, unless circumstances give rise to special enrollment rights described below, or unless other enrollment opportunities are available for a particular Benefit.

Special Enrollment Rights

BENEFITS

in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing.

The Claims Fiduciary will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended to 120 days under certain circumstances.) Any denial of your appeal will be provided in writing and will include the reasons for the denial, with reference to the

explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

You have 180 days to appeal an adverse benefit determination. You will be notified of the Claims Fiduciary's decision upon review within a reasonable period of time, but no later than 45 days after the Claims Fiduciary receives your appeal request. The 45-day period may be extended for an additional 45-day period if the Claims Fiduciary determines that special circumstances (such as the need to hold a hearing) require an extension of time. You will be provided with written notic.65 0 Td[w)4 (i2t(c)6

Fiduciary within 30 days of receipt of the claim, so long as all needed information was provided with the claim. The Claims Fiduciary will notify you within the 30-day period if additional information is needed to process the claim and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims Fiduciary will notify you of a denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

Pre-Service Claims are those claims that require certification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Fiduciary within 15 days of receipt of the claim. If you filed a Pre-Service Claim improperly, the Claims Fiduciary will notify you of the improper filing and how to correct it within 5 days.

After reviewing the revised Pre-Service Claim, the Claims Fiduciary will notify you of any additional information needed within 15 days and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Fiduciary will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically as soon as possible, but not later than 72 hours after the Claims Fiduciary receives all necessary information, or such other timeframe as required under federal law, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.
- If you filed an Urgent Care Claim improperly, the Claims Fiduciary will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the Claims Fiduciary will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after the Claims Fiduciary's receipt of the requested information or the end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided as soon as possible, and the Claims Fiduciary will notify you of the determination within 24 hours after receipt of the claim, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If your circumstance warrants an expedited appeals procedure, then you should contact the Claims Fiduciary immediately. You will be asked to explain, in writing, why you believe the claim should have been processed differently and to provide any additional material or information necessary to support the claim.

You will be provided with written or electronic notification of the decision on your appeal as follows:

- For appeals of Pre-Service Claims, the appeal will be conducted, and you will be notified by the Claims Fiduciary of the decision within 15 days from receipt of a request for appeal.
- For appeals of Post-Service Claims, the appeal will be conducted, and you will be notified by the Claims Fiduciary of the decision within 30 days from receipt of a request for appeal.
- For appeals of Concurrent Care Claims, the appeal will be conducted, and you will be notified by the Claims Fiduciary of the decision before treatment ends or is reduced, or within 24 hours from receipt of a request for appeal if the claim is a request for extension involving urgent care.

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your doctor should call the Claims Fiduciary as soon as possible.
- The Claims Fiduciary will provide you with a written or electronic determination as soon as possible, but not later than 72 hours following receipt of your request for review of the determination.

Notice of Adverse Decision on Appeal

Every notice of an adverse determination on appeal will be provided in a culturally and linguistically appropriate manner and will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, and a description of the claims procedures for any additional level of appeal and the applicable time limits, external review rights, and a statement of your right to bring a civil action under Section 502(a) of ERISA after exhausting the Plan's claims procedures. The notice will also include a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim, as well as a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit. The notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

External Review

You may have the right to request an external review of a group health plan claim involving medical judgment, as determined by the external reviewer, or a coverage rescission. You must request the external review within four months of the date you receive an adverse benefit determination. If your request for an external review is determined eligible for such a review, an independent organization will review the Claims Fiduciary's decision and provide you with a written determination, as described in the Benefits documents.

The external review decision is binding on you and the Plans, except to the extent other remedies are available under federal law. The external review process does not apply to an adverse benefit determination or final internal adverse benefit determination that is not related to medical judgment or coverage rescission.

Exhaustion

If you do not exercise your appeal right within the timeframe set forth in the claims procedures described in the official plan document or summary plan description for the applicable Benefit policy, you may lose your right to file suit in a state or federal court.

Limitations Period

Unless stated otherwise in the official plan document or summary plan description for the applicable Benefit, any lawsuit on a claim for benefits under the Plan must be initiated within 12 months after the date of final disposition of the claim.

CONTINUATION COVERAGE

Different types of continuation coverage that may apply to particular Benefits, as highlighted below, including state laws that may provide continuation and conversion coverage.

Continuation Coverage

eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law. COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Benefit documents or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this Section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Medical or Dental Benefit is

- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

Qualified beneficiaries will be offered COBRA continuation coverage only after the Plan Administrator has been notified that a qualifying event has occurred. The Employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all 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 within 60 days after the qualifying event occurs. You must provide this notice to: the Plan Administrator, University of New England, 11 Hills Beach Road, Biddeford, ME, 04005, 207-602-2394.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

want Part B later. If you elect

MISCELLANEOUS PROVISIONS

Plan Administrator

The administration of the Plan is under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discriminating among them. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures,

Assistance With Your Questions. If you have any questions about the Plan or the Benefits, you should contact the Plan Administrator. If you have any questions about this statement or about

APPENDIX A

BENEFITS

Refer to Appendix B for definitions of the capitalized terms in this Appendix A.

Medical	
Provider or Program Administrator Contact Information	Cigna 500 Southborough Dr. #302 South Portland ME 04106 1-866-494-2811 or www.mycigna.com
Funding Medium	Fully Insured
Claims Fiduciary	Cigna
Eligibility and entry date	All full-time and half-time Employees

Eligibility and entry date	Any Employee who: (i) retires from the Employer at age 60 or older (ii) with at least 20 years of continuous service in a full-time or half-time regularly budgeted position, as described in the Employer's personnel handbook, (iii) is covered under the Employer's major medical plan immediately prior to retirement, and (iv) elects retiree medical coverage at the time of retirement. Retiree medical coverage terminates when the retiree becomes eligible for Medicare Part A, B, and D. Eligibility for retiree medical coverage for an otherwise eligible spouse terminates when the spouse becomes eligible for Medicare Part A, B, and D. Dependents will be eligible for retiree medical coverage so long as either the retiree or any eligible spouse remains enrolled in retiree medical coverage under the Plan. First day of the calendar month coincident with or next following the Employee's retirement.
Dental	
Provider or Program Administrator Contact Information	Delta Dental 1022 Portland Road, Suite 2 Saco, ME 04072 1-800-832-5700 www.nedelta.com
Funding Medium	Self-insured
Claims Fiduciary	Delta

Vision	
Provider or Program Administrator Contact Information	Cigna 500 Southborough Dr. #302 South Portland ME 04106 1-866-494-2111 www.mycigna.com
Funding Medium	Fully Insured
Claims Fiduciary	Cigna

Eligibility and entry date	All full-time Employees in a regularly budgeted position, as described in the Employer's personnel handbook. First day of the calendar month coincident with or next following date of hire or change in status.
Supplemental Life	

Provider or Program
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