

UNIVERSITY OF DAYTON EMPLOYEE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

The University of Dayton (the "University") maintains the University of Dayton Employee Benefit Plan (the "Plan") for the exclusive benefit of the participants and their eligible dependents as defined by the underlying insurance certificate(s) of coverage.

This information goes with your Summary of Benefits Booklet/Insurance Certificates issued by an insurance company to give you important information about your benefits under University of Dayton Employee Benefit Plan, called the "Plan". These documents, together, make up the "summary plan description" or "SPD" for the Plan, as required by ERISA.

1. Introduction

The University maintains the Plan for the exclusive benefit of its eligible employees and when applicable, their eligible dependents, as defined by the underlying insurance certificate(s) of coverage. The Plan provides benefits through the following component benefit programs:

- Health Benefit Plan
- Dental Benefit Plan
- Vision Benefit Plan
- Life Benefit Plan
- Disability Benefit Plan(s)
- Voluntary Life and/or AD&D Benefit Plan(s)
- Long Term Care Plan
- Health Flexible Spending Account Benefit Plan

The benefit programs may require you to make an annual election to enroll for coverage and may require you to pay a portion of the premiums. Each benefit program is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description (SPD) or other governing document prepared by the University. A copy of each booklet, summary, or other governing document is attached to this document.

This document and its Attachments constitute the SPD for each of the component plans to the extent required by ERISA.

2. General Information About the Plan

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| Plan Name | University of Dayton Employee Benefit Plan |
| Type of Plan | Welfare plan providing benefits as detailed above. |
| Plan Year | The plan year is January 1 st - December 31 st . The last day of the plan year is December 31 st . |
| Plan Number | The plan number is 501. |
| Effective Date | The effective date of this SPD is July 1, 2015. The Plan was originally established on July 1, 1988 and has been amended from time to time. |
| Funding Medium and Type of Plan Administration | The following benefits are fully insured: Dental Benefit Plan Vision Benefit Plan Life Benefit Plan Disability Benefit Plan(s) Voluntary Life and/or AD&D Benefit Plan(s) Voluntary Product Benefit Plan(s) |

The Plan is fully insured with respect to these benefits. The University has entered into contracts with various insurance companies to provide Plan benefits. The various insurance companies are responsible for paying the Plan benefits. Claims for benefits are sent to the various insurance companies and the claims are processed in accordance with the terms listed in the attached booklets prepared by the various insurance companies. The University and various insurance companies are responsible for administering the Plan as outlined below.

The University and employees both may contribute towards the cost of the coverage under the Plan. The University's portion of the contributions is paid out of the University's general assets. The employees' share of the contributions is made through employees' pre-tax payroll deductions for the Health Benefit Plan, Dental Benefit, Vision Benefit Plan and the Health Flexible Spending Account Benefit Plan. All other benefits do not include pre-tax employee contributions. The Plan Administrator will provide the employees periodically a schedule of the amounts, if any, they must pay to participate in each of the component benefit programs. The Plan Administrator reserves the right, at any time, to modify the amount employees have to contribute to participate in the Plan.

The Health Benefit Plan and the Health Flexible Spending Account Benefit Plan are self funded. The Health Flexible Spending Account Benefit Plan is integrated with the Health Benefit Plan and the Health Flexible Spending Account Benefit Plan is funded exclusively by the participants' pre-tax salary deferrals. The benefits under both the Health Flexible Spending Account Benefit Plan and the Health Benefit Plan are paid out of the University's general assets.

The TPAs that administers the self-insured Health Benefit Plan and the Health Flexible Spending Account Benefit Plan only provide administrative services and does not insure or fund the benefits. Therefore, the University and not the TPAs are ultimately responsible for paying benefits under the Health Benefit Plan and the Health Flexible Spending Account Benefit Plan and those benefits are paid out of the University's general assets.

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| Plan Sponsor | University of Dayton 300 College Park Dayton, Ohio 45469-1614 Telephone 937-229-2541 |
| Plan Sponsor's Employer Identification Number | 31-0536715 |
| Claims Administrator/ Insurance Companies | For Health Benefits Anthem Blue Cross and Blue Shield Post Office Box 105187 Atlanta, Georgia 30348-5187 Telephone 800-552-9159 For Dental Benefits Superior Dental Care, Inc. 6683 Centerville Business Parkway Dayton, Ohio 45459 Telephone 800-762-3159 For Vision Benefits EyeMed Vision Care Post Office Box 8504 Mason, Ohio 45040 Telephone 800-334-7591 |

For Life and AD&D Benefits
Hartford
Post Office Box 14299
Lexington, Kentucky 40512-4299
Telephone 888-463-1124

For Long Term Care Benefits
Genworth
Post Office Box 64010
St. Paul, Minnesota 55164-0010
Telephone 800-416-3624

For Disability Benefits
Hartford
Post Office Box 2999
Hartford, Connecticut 06104-2999
Telephone 800-523-2233

For Health Flexible Spending Account Benefits
myCafeteria Plan
432 East Pearl Street
Miamisburg, Ohio 45342
Telephone 800-865-6543

Plan Administrator University of Dayton
300 College Park
Dayton, Ohio 45469-1614
Telephone 937-229-2541
Attention: Human Resources Manager

Named Fiduciary University of Dayton
300 College Park
Dayton, Ohio 45469-1614
Telephone 937-229-2541

**Agent for Service of
Legal Process** University of Dayton
300 College Park
Dayton, Ohio 45469-1614
Telephone 937-229-2541
Attention: Human Resources Manager

Important Disclaimer Plan benefits are provided pursuant to the various insurance contracts and pursuant to governing plan documents adopted by the University. If the terms of this document conflict with the terms of such insurance contracts or governing plan documents, then the terms of the insurance contracts or governing plan documents will control, rather than this document, unless otherwise required by law. This SPD (as well as the incorporated documents) will be considered the plan document for any provision not addressed in the plan document.

3. Eligibility and Participation Requirements

Eligibility and Participation An eligible employee with respect to the Plan will be any common-law employee of the University who is eligible to participate in and receive benefits under one or more of the component benefit programs. To determine whether you or your family members are eligible to participate in a component benefit program, please read the eligibility information contained within the Attachments for the applicable component benefit programs as provided by the insurance companies and/or TPA. A summary of this information is set forth below.

Summary of Eligibility and Participation Provisions

Listed below are the eligibility requirements for each component benefit program:

All Plan benefits except the Long Term Disability Benefit Plan are available to both full time and part time employees. A part time employee is an employee regularly scheduled to work at twenty hours (20) hours per week. Only full time employee who is regularly scheduled to work at least thirty five (35) hours per week for at least nine months are eligible for the Long Term Disability Benefit Plan. There is no waiting period for any of the Plan benefits except for the life and disability plans. An employee will enter the life and disability plans as of the first day of the month following the date if the employee is otherwise eligible to participate in the life and disability plans.

Exclusions: Part time on call, students and adjunct professors are not to participate in any of the benefits offered under this plan.

The benefit programs may require that you make an annual election to enroll for coverage. If you are an eligible employee, you may begin participating in the Plan upon your election to participate in a component benefit program in accordance with the terms and conditions established for that program. You must consult the eligibility requirements and enrollment procedures listed in each component benefit program for additional information to fully determine all of the participation requirements.

Large Employer Health Care Reform Provisions

Introduction

This Section applies if the University is considered a "large employer" under health care reform. Generally speaking, a large employer is defined under the statute as an employer that has 50 or more full time or full time equivalent employees during the previous calendar year. Health care reform requires large employers to offer quality/affordable coverage to full time employees or pay a penalty. A full time employee is defined under the law as an employee regularly scheduled to work at least 30 hours per week. However, some times the employer is not able to ascertain whether or not an employee will regularly work at least 30 hours per week. These employees are called "variable hour employees." This section only applies to large employers that hire variable hour employees and only applies to the Health Benefit Plan portion of this SPD.

General Rule

A full-time employee is defined under the statute as an employee that works, on average, at least 30 hours per week.

Variable hour employees, as defined below, that average 30 hours per week during a Measurement Period will be eligible to participate in the Health Benefit Plan during the Stability Period. Variable hour employees that do not average 30 hours per week during a Measurement Period are not eligible for medical benefits for the following Stability Period.

Variable Hour Employee Defined

An employee is a variable hour employee if, based on the facts and circumstances, it cannot be determined that the employee is reasonably expected to work on average at least 30 hours per week. Variable hour employees also include seasonal employees who are (1) employed for six (6) months or less each year and (2) hired around the same time each year due to the nature of the position.

Measurement Periods

The Standard Measurement Period for ongoing variable employees (i.e. those employees have completed at least one Standard Measurement Period) will begin on each October 1st and end on the following September 30th. The Initial Measurement Period for a new variable hour employee will be the twelve consecutive month period beginning on the first of the month following the date of hire.

Administrative Period

The Plan Administrator uses the Administrative Period to determine if the variable hour employee has, in fact, worked an average of 30 hours per week during the Measurement

Period. The Plan Administrator also uses the Administrative Period to process the variable hour employee's enrollment in the Health Benefit Plan if the variable hour employee is otherwise eligible to participate in the Plan. The Administrative Period for ongoing employees will be October 1st through December 31st. The Administrative Period for new variable hour employees will be the sixty (60) day period beginning on the day after the initial measurement period.

Stability Periods

The Stability Period for ongoing employees will be the calendar year. The Stability Period for new variable hour employees will be the twelve month period beginning immediately following the Administrative Period.

Coverage Periods

If the variable hour employee averages at least 30 hours per week during the Measurement Period, that variable hour employee will be treated as a full time employee during the following Stability Period regardless of the number of hours that employee works during that Stability Period. If the variable hour employee averages less than 30 hours per week during the Measurement Period, that employee will be treated as a part time employee during the following Stability Period regardless of the number of hours that employee works during that Stability Period unless there is a Change in Employment Status.

Maximum Exclusionary Period New Variable Hour Employee

Regardless of any other provision in this SPD, if a new variable hour employee has averaged at least thirty (30) per week during the initial Measurement Period, that variable hour employee will be offered health coverage no later than the end of the thirteen and fractional month from the date of hire.

Excluded Employees

Part time employees, volunteer employees, student employees participating in a federal or state study program and seasonal employees are not eligible to participate in the plan. Part time employees are employees that work less than 30 hours per week. Seasonal employees are defined as employees customarily hired the same time each year for a period of less than six months.

Change in Employment Status

If an individual is hired as a part time, variable hour or seasonal employee and is converted to full-time status during his or her initial measurement period that employee will be considered full time immediately. Therefore, the employee will be eligible to participate in the Plan at that time.

Termination of Participation

Your participation and the participation of your eligible family members in the Plan will terminate on the same day you terminate employment with the University. However, certain benefits may continue until the end of the month in which your employment terminates or beyond that date if applicable. Coverage also may terminate if you fail to pay your share of an applicable premium, if your hours drop below any required hourly threshold, if you submit false claims, or for any other reason as set forth in the certificate of insurance, benefit booklets, benefit summaries, or other governing documents for the component benefit program. You should consult the applicable Attachments for specific termination events and information.

Continuation Coverage Under COBRA and USERRA

Any mention of COBRA rights within this document as well as the Model Notice and Notice of Qualifying event form are only applicable if your employer is subject to COBRA. As a general rule, COBRA applies to employers with 20 or more employees. If COBRA does not apply there may be a state law that allows individual to continue participating in certain Plan benefits.. You should contact the Plan Administrator to determine if this plan is, in fact, subject to COBRA. This document does not guarantee rights under COBRA or any state law that may allow an individual to continue participating in certain Plan benefits.

If eligible coverage for you or your eligible family members ceases because of certain “qualifying events” specified in COBRA (such as termination of employment, reduction in hours, divorce, death, or a child’s ceasing to meet the definition of dependent), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time. You must notify your Plan Administrator should a qualifying event occur i.e. divorce, separation, birth or adoption of a child or when a child ceases to be a dependent under the terms of the Plans. We have provided a Notice of Qualifying Event Form on the last page of this document for you to notify the Plan Administrator should you have a qualifying event.

If you have any questions about your COBRA rights, please read the benefit booklets as provided by the insurance company or TPA. Please contact the Plan Administrator if you need another copy. There may be other coverage options for you and your family through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. For more information about health insurance options through a Health Insurance Marketplace visit www.healthcare.gov.

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to USERRA. More information about coverage available pursuant to USERRA is included in the certificate of insurance, benefit booklet or SPD.

4. Summary of Plan Benefits

Benefits and Contributions

The Plan provides benefits to you and your eligible dependents as defined by the underlying insurance certificate(s) of coverage. A summary of each benefit provided under the Plan is set forth in the attached certificate of insurance, benefit booklet, SPD, or other governing document among the applicable Attachments. The Plan is not considered grandfathered under health care reform.

The cost of the benefits provided through the component benefit programs will be funded in part by University contributions and in part by the employees’ contributions. The employees’ share of the contributions is made through employees’ pre-tax payroll deductions for the Health Benefit Plan, Dental Benefit, Vision Benefit Plan and the Health Flexible Spending Account Benefit Plan. All other benefits do not include pre-tax employee contributions. The University will make its contributions, out of the University’s general assets, in an amount that (in the University’s sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The University will pay its contribution and your contributions to the insurance carriers periodically as soon as administratively possible. The Plan will, within three months from date of receipt or rebate, return any refunds or rebate from an insurance company with those participants entitled to a portion of those refunds in accordance with any applicable statute.

Qualified Medical Child Support Orders

With respect to the medical benefits, the Plan will also provide benefits as required by any qualified medical child support order (QMCSO) (defined in ERISA 609(a)). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

**Special Rights on
Childbirth**

Group health plans and health insurance issuers offering group insurance coverage 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 normal 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 the above periods. In any case, such 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 the above periods.

5. How the Plan Is Administered

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The Director of Employee Benefits and Wellness of the University is the person who has been designated to act on behalf of the Plan Administrator.

The principal duty of the Plan Administrator is 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. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibility.

The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan. All decisions by the Plan Administrator will be afforded the maximum deference permitted by law. The Plan Administrator will have the right to make adjustments or withhold future benefits if there has been a mistake with respect to eligibility or the amount of benefits paid under the Plan. The Plan Administrator makes no representations regarding the tax treatment of Plan benefits. The Plan Administrator may require and the individual agrees to provide documentation, in a timely manner, that he or she is eligible to participate in the Plan or any other information the Plan Administrator may need to properly administer the Plan. The Plan Sponsor will, to the extent permitted by law, indemnify the Plan Administrator. The University will bear its incidental costs of administering the Plan.

**Power and Authority
of Insurance
Company, TPA and
University**

The insurance companies for the insured products are responsible for (a) determining eligibility for and the amount of any benefits payable under their respective component benefit plans; and (b) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective component benefit plans. The University will be considered a fiduciary for the self funded benefits and for the insured products to the extent the University has discretionary authority

For Health Benefits

Anthem Blue Cross and Blue Shield
Post Office Box 105187
Atlanta, Georgia 30348-5187
Telephone 800-552-9159

For Dental Benefits

Superior Dental Care, Inc.
6683 Centerville Business Parkway
Dayton, Ohio 45459
Telephone 800-762-3159

For Vision Benefits

EyeMed Vision Care
Post Office Box 8504
Mason, Ohio 45040
Telephone 800-334-7591

For Long Term Care Benefits

Genworth
Post Office Box 64010
St. Paul, Minnesota 55164-0010
Telephone 800-416-3624

For Life and AD&D Benefits

Hartford
Post Office Box 14299
Lexington, Kentucky 40512-4299
Telephone 888-463-1124

For Disability Benefits

Hartford
Post Office Box 2999
Hartford, Connecticut 06104-2999
Telephone 800-523-2233

For Health Flexible Spending Account Benefits

myCafeteria Plan
432 East Pearl Street
Miamisburg, Ohio 45342
Telephone 800-865-6543

Questions

If you have any general questions regarding the Plan or regarding your eligibility for, or the amount of any benefit, please contact the Director of Employee Benefits and Wellness, who acts on behalf of the Plan Administrator. If you have any question regarding your eligibility for, or the amount of, any benefit payable under the Plan, please contact the appropriate insurance company.

6. Circumstances That May Affect Benefits

Denial, Recovery, or Loss of Benefits

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates. See Section 4.

Your benefits will also cease upon termination of the Plan. Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), coordination of benefits or denial of benefits. For example, benefits may be denied under a certain benefit program if you have a preexisting condition and incur costs within the exclusionary period. In addition, certain benefits may be rescinded or retroactively terminated for fraud or an intentional misrepresentation of material fact and you may have to repay the Plan. You should consult the certificate of insurance booklets, SPDs and other governing documents among the applicable Attachments for additional information.

7. Amendment or Termination of the Plan

Amendment or Termination

The University, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the University or any of its delegates.

The Vice President of Human Resources of the University may sign insurance contracts for this Plan on behalf of the University, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to

be administrative in nature or advisable in order to comply with applicable law.

8. No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the University to the effect that you will be employed for any specific period of time.

9. Claims Procedures

Claims for Benefits/ Insured Benefit

For purposes of determining the amount of, and entitlement to, benefits of the component benefit programs provided under insurance or contracts, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance or contract. To obtain benefits from the insurer of a component benefit program, you must follow the claims procedures under the applicable insurance or contract, which may require you to complete, sign, and submit a written claim on the insurer's form. In that case, the form is available from the Plan Administrator.

The insurance company (or Plan Administrator) will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurance company denies your claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurance company for a review of the denied claim. The insurance company will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). Unless specifically listed in a component benefit program or an applicable statute all claims for Plan benefits must be submitted within one year from the date the claim was incurred. Additionally, unless specifically listed in a component benefit program or an applicable statute any lawsuit for benefits under the Plan must be filed within one year from the date of any final decision on the claim.

See the attached certificate of insurance or booklet for more information about how to file a claim and for details regarding the insurance company's claims procedures.

10. Statement of ERISA Rights

Your Rights

As a participant in the 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 and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, 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, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights

You may be able to continue health care coverage for yourself or your eligible 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 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 Plan 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 that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (discussed in Section 9), you may file suit in a state or 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 directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Note that a cafeteria plan (including premium only plan) is not covered by ERISA and this Statement of the ERISA Rights do not apply to these programs. However, Health FSAs are considered health plans and, as such, are subject to ERISA and this statement of ERISA Rights does apply to Health FSAs. Also, special COBRA rules apply to Health FSA's.

UNIVERSITY OF DAYTON
MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health, dental, and/or vision plan(s) (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become 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, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). 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 Plan's Summary Plan Description 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 notice. 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 Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Please note that all notifications to the Plan Administrator must be in writing. See the last page of this document for the Notice of Qualifying Event Form.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;

- 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."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries 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;
- 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 complete the Notice of Qualifying Event Form found on the last page of this document. The form must then be provided to: the University of Dayton at the address listed below.

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. Please note; special rules apply to the Health Flexible Spending Account Benefit Plan with regard to COBRA coverage periods.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must complete the attached form and send it to the Plan Administrator using the address listed below.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

University of Dayton
300 College Park
Dayton, Ohio 45469-1614

UNIVERSITY OF DAYTON
NOTICE OF QUALIFYING EVENT FORM

The University of Dayton provides you and your family valuable benefits in the form of health, dental, and/or vision coverage. As the attached Notice explains, COBRA permits certain individuals to continue their coverage under the Plans under certain circumstances when that coverage would otherwise end. One of the requirements under COBRA is that you or any member of your family must notify the Plan Administrator if one of the following events occurs:

- You (the employee) become divorced or legally separated;
- A child is born or adopted;
- A child ceases to be a dependent under the terms of the Plans; or
- If anyone on COBRA becomes married, divorced or acquires a child
- A person is determined to be disabled and becomes entitled to Medicare

It is imperative you complete and return this form to the Plan Administrator within sixty (60) days if there is a change in marital status or a child loses dependency status. You must complete and return this notice of Qualifying Event to the Plan Administrator within thirty (30) days if a child is born or adopted. Failure to complete and return this form to the Plan Administrator in a timely manner will result in the forfeiture of valuable benefits.

Please complete the following information:

| | |
|-----------------------------|------------------|
| Employee's Name and Address | Today's Date |
| _____ | _____ |
| _____ | Telephone Number |
| _____ | _____ |

Please check the appropriate items:

| | |
|-------|--|
| _____ | I have obtained a divorce or legal separation. |
| _____ | A child has been born or adopted. |
| _____ | A child no longer qualifies as a dependent. |
| _____ | Received notice from Medicare regarding eligibility for disability benefits. |
| _____ | Date of Event. |

This form must be completed and mailed, via first class mail, to the following address within sixty (60) days (thirty (30) days if a child is born or adopted) of the date the above event occurred:

Plan Administrator
University of Dayton
300 College Park
Dayton, Ohio 45469-1614