SUMMARY PLAN DESCRIPTION FOR BENEFITS ELIGIBLE EMPLOYEES

Effective January 1, 2019

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INTRODUCTION

Tufts University recognizes that benefits are an important part of your overall compensation. The University's benefit plans have been designed to provide security for you and your family and to assist you with planning for the future. The University's "welfare benefit plans" include the Tufts University Health Plan, Dental Plan, Vision Plan, Health Care Flexible Spending Account Plan, Dependent Care Flexible Spending Account Plan, Group Term Life Insurance Plan (Basic, Supplemental, Dependent), Group Accidental Death & Dismemberment Plan, Group Long Term Disability Plan, Business Travel Accident Insurance Plan, Group Long Term Care Plan, Employee Assistance Plan, and Reduction in Force Policy; its "pension plans" include the Tufts University University-Funded Retirement Plan – 401(a) (the University-Funded plan) and Self-Funded Retirement Plan – 403(b) (the self-funded plan). For federal reporting purposes, each welfare benefit plan is a component or sub-plan of the Tufts University Group Welfare Benefit Plan (referred to as the "Plan"). Some of the terms in this document are capitalized. These terms are defined in the Glossary.

Each welfare benefit plan has its own requirements for eligibility and enrollment, as set forth in the Welfare Benefit Contracts. These requirements are described in the appropriate sections of this document. (Some of the welfare benefit plans also have formal written documents in addition to or instead of the Welfare Benefit Contracts, in which case reference to the relevant Welfare Benefit Contract also includes the separate plan document). The complete eligibility and enrollment requirements for the pension plans are set forth in the formal University-Funded Retirement Plan and Self-Funded Retirement Plan documents. Your rights to review all official plan documents are described in the section of this booklet entitled *Your Rights as a Plan Member*.

This booklet, together with the Welfare Benefit Contracts identified in Appendix A constitutes the written document for the Group Welfare Benefit Plan, and is also the Summary Plan Description (SPD) for the welfare benefit plans and pension plans, in accordance with the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, and U.S. Department of Labor Regulations. The provisions of the Welfare Benefit Contracts are incorporated by reference into this Plan document. If there is any conflict between this document and the official plan documents for a particular benefit, including the Welfare Benefit Contracts, the official documents will control.

Because the benefits you receive through the welfare benefit and pension plans will be of importance to you and your family, you should retain this SPD as part of your permanent records, but be advised that it is only a summary. The SPD summarizes who is eligible for benefits and the nature of the benefits available. The SPD is not meant to change the benefit plans or any legal instrument related to the creation, operation, funding, or benefit payment obligations of the benefit plans.

The University is the Plan Administrator and is the sole judge of the application and interpretation of the benefit plans. As Plan Administrator, the University has the discretionary authority to construe the provisions of the benefit plans, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits under the benefit plans. The Plan Administrator also has the authority to delegate certain of its powers and duties to a third party. Benefits under the benefit plans will be paid only if the Plan Administrator (or its delegate) decides in its discretion that the applicant is entitled to them under the terms of the plan. The decisions of the Plan Administrator (or its delegate) in all matters relating to a benefit plan (including, but not limited to, eligibility for benefits, benefit plan interpretations, and disputed issues of fact) will be final and binding on all parties.

SUMMARY OF THE BENEFIT PLANS

This chart summarizes the benefits available under the benefit plans. For a more complete description of the benefits, please refer to the specific sections in this booklet and the other descriptive materials you receive from the University and the benefit plan vendors. The various benefit plan vendors are identified in Appendix A at the back of this booklet.

Benefit Plan	Summary Of Benefit Options
Health	You and your eligible family members may elect health benefits under the Health Plan and choose from 3 health coverage options. There is no lifetime maximum on health expenses relating to "essential health benefits" under the employee Health Plan. See the section entitled *Health – Coverage Options* at page 19.
Dental	You and your eligible family members may elect dental benefits under the Dental Plan option which provides coverage for preventive/diagnostic, basic restorative, major restorative care, and orthodontia. Coverage is available with both in- and out-of-network providers and through the University's Dental School Clinic. The Dental Plan option has a calendar year maximum benefit of $1,500 per covered individual. There is a separate lifetime maximum of $1,000 for orthodontia per covered individual.
Vision	You and your eligible family members may enroll in the Vision Plan, which is designed to encourage you to maintain your vision through regular eye examinations and to help with vision care expenses for required glasses or contact lenses.
Flexible Spending Accounts (FSA)	Per IRS rules for 2019, you may elect to set aside part of your salary on a pre-tax basis up to $2,700 per year per employee for health care expenses and up to $5,000 per year per family for dependent care expenses.

Benefit Plan	Summary Of Benefit Options	
Life Insurance	Basic Coverage	The amount of coverage is equal to one (1) times your basic annual earnings, rounded to the next highest $1,000, with a maximum of $1,000,000. This coverage is provided at no cost to you by the University.
	You may choose from the following elect supplemental and dependent life insurance coverage options:	
	Supplemental Coverage	You may elect up to five (5) times your annual base salary, rounded up to next highest $1,000, or a $2,000,000 maximum. Amounts in excess of three (3) times your annual base salary (maximum of $750,000) require you to apply for coverage and receive approval from the insurance company.
	Dependent Life Insurance	*Spouse/ Domestic Partner (DP)*: You may choose from two options for life insurance for your spouse/DP: $25,000 or $50,000. Note: Your Spouse's/DP's coverage amount cannot exceed 100% of your combined employee basic and supplemental life insurance coverage amount. Coverage of up to $50,000 is guaranteed issue if elected at initial enrollment. Any other time, enrolling or increasing from $25,000 to $50,000 requires you to apply for coverage and receive approval from the insurance company. *Child(ren):* You may also elect life insurance coverage for each of your dependent children in the amount of $10,000. No separate application is required by the insurance company.
Voluntary Accidental Death and Dismemberment Insurance (AD&D)	The AD&D program offers you the opportunity to elect coverage levels from one (1) to five (5) times your annual base salary, rounded to the next $1,000, with a maximum of $1,000,000. No separate application is required by the insurance company.	
Employee Assistance Plan (EAP)	The EAP is a confidential counseling service providing professional help to you, your dependents, and household members for any type of personal problem such as couples, parent/child, or elder issues, stress, financial or legal difficulties, alcohol or drugs. EAP services include initial assessment, up to 3 visits of short-term counseling, referral and follow-up.	

<table>
<tr><th>Benefit Plan</th><th colspan="3">Summary Of Benefit Options</th></tr>
<tr><td rowspan="4">Long Term Disability (LTD)</td><td colspan="3">You may elect Long Term Disability benefits and choose from <u>one</u> of the following coverage options:</td></tr>
<tr><td>Option 1</td><td colspan="2">The lesser of 40% of your basic monthly earnings or $12,000 (less any other income benefits).</td></tr>
<tr><td>Option 2*</td><td colspan="2">The lesser of 60% of your basic monthly earnings or $12,000 (less any other income benefits).</td></tr>
<tr><td colspan="3">• If you apply and are approved, benefits begin after a 180-day waiting period.
• Enhanced benefits include a Conversion Provision and a Critical Illness benefit.
• A Pre-existing Condition Limitation will apply during your first year on the plan or when you increase your coverage.

* Effective January 1, 2017 newly hired employees or newly eligible employee are automatically enrolled in Option 2 (60% benefit). This benefit may be reduced to Option 1 (40%) or waived within the 31-day new hire enrollment period or during any subsequent annual Open Enrollment period.

Coverage is guaranteed issue if elected at initial enrollment. Any other time, enrolling or increasing your LTD benefit requires you to apply for coverage and receive approval from the insurance company.</td></tr>
<tr><td>Long Term Care</td><td colspan="3">This benefit is no longer offered as of June 30, 2013. Please see the Long Term Care section of this document for further details.</td></tr>
<tr><td>Reduction in Force (RIF) Policy</td><td colspan="3">If you are involuntarily terminated due to a reduction in force (RIF), you may be eligible for RIF benefits.</td></tr>
<tr><td>Business Travel Accident (BTA) Plan</td><td colspan="3">If you are traveling for business on behalf of Tufts University, you are eligible for BTA benefits.</td></tr>
<tr><td rowspan="4">University-Funded Retirement Plan – 401(a)</td><td colspan="3">The University makes contributions to the University-Funded Retirement Plan on behalf of Eligible Employees as follows:</td></tr>
<tr><td>Your Age Before First Day of Month of Contribution</td><td>Contribution as a % of Covered Salary Up to Social Security Wage Base</td><td>Contribution as a % of Covered Salary Over Social Security Wage Base</td></tr>
<tr><td>21 through 39</td><td>5%</td><td>10%</td></tr>
<tr><td>40 or over</td><td>10%</td><td>15%</td></tr>
</table>

Self-Funded Retirement Plan – 403(b)	Per IRS rules, you may elect to set aside part of your salary on a pre-tax basis up to $18,500 in 2018. If you are age 50 or older by December 31, 2018, you may contribute an additional $6,000 (total of $24,500) in 2018. These limits are adjusted periodically for cost-of-living and may increase for 2019.

ELIGIBILITY

Employee Eligibility

Health, Dental, Vision, Flexible Spending Accounts, Life Insurance, Accidental Death & Dismemberment Insurance (AD&D), Long Term Disability Insurance, Business Travel Accident Insurance, and Long Term Care Insurance

If you are an active, regular employee at the University, you are eligible to participate in the Plans providing health, dental, vision, flexible spending accounts, life insurance, AD&D, long term disability insurance, and business travel accident insurance provided that you are one of the following:

- an exempt or non-exempt employee regularly scheduled to work 17.5 hours or more a week, with a minimum 90-day employment period; or
- a faculty member with at least a half time (as determined by the academic department), two-semester appointment; or
- a party to a job share contract (a job share contract is any contractual arrangement under which two employees, who each normally work at least 17.5 hours per week, fulfill the responsibilities of one job in accordance with the University's job sharing policy and all personnel policies and procedures then in effect), or for Health Plan benefits only, if you are required to be covered under Health Care Reform; or
- for Health Plan benefit only, if you are required to be covered under Health Care Reform; or
- for long term care benefits only, if you were enrolled in the Long Term Care Insurance Plan as of June 30, 2013.

In addition, certain grandfathered employees are eligible to participate in long-term care benefits.

An Eligible Employee does not include (1) an employee covered by a collective bargaining agreement unless the agreement provides for participation; (2) any individual employed by the University who is in a division, department, unit, or job classification that the University designates as ineligible to participate in the benefit plans, including any individual whose primary affiliation with the University is as a student, whether or not a candidate for a graduate or undergraduate degree from the University; (3) any person performing services pursuant to an arrangement with a leasing organization, including but not limited to a "leased employee" within the meaning of Section 414(n) of the Internal Revenue Code; and (4) independent contractors and other persons who are not treated by the University as employees for purposes of withholding federal employment taxes, regardless of any contrary governmental or judicial determination relating to such employment status or tax withholding, or (5) any Employee who is classified by the University as a Postdoctoral employee, except as described below.

Special rules apply for eligibility under the Reduction in Force Policy. An employee must satisfy specific eligibility requirements and have their employment involuntary terminated due to a reduction in force. The Plan Administrator will advise an employee if they become eligible for benefits under the Policy.

Post Doctoral Scholar Eligibility

If you are a Postdoctoral Scholar at the University, you are eligible to participate in the Tufts University Flexible Spending Accounts and the Self-Funded Retirement Plan as follows:

- Postdoctoral Scholars paying FICA tax may contribute to the Self-Funded Retirement Plan.

- Postdoctoral Scholars holding twelve-month appointments may contribute to the Tufts University Health and/or Dependent Care Flexible Spending Account (FSA) (per policy change effective January 1, 2009).

Dependent Eligibility

For benefits-eligible employees, your "dependents" may be eligible for coverage under the University's Plans providing health, dental, vision, dependent life insurance, and long term care benefits. Eligible dependents include your:

Spouse/Domestic Partner (DP). The term "Spouse" means your legal spouse as described below. For purposes of this booklet, the term "Spouse" also includes your Domestic Partner or "DP," except as described below or in other sections of this booklet.

- Effective June 26, 2013, a legal spouse includes a same-sex spouse to whom you are legally married under the laws of a state that recognizes same-sex marriages regardless of where you reside. You are not treated as legally married if you have entered into a registered domestic partnership, civil union, or other formal relationship under state law that is not a marriage.

- The term "Spouse" does not include your "DP" for purposes of the Flexible Spending Accounts, the University-Funded Retirement Plan, and the Self-Funded Retirement Plan. A "DP" is a domestic partner with whom (1) you are not legally married under a state law that recognizes same-sex marriages and (2) you have filed with the University an 'Affidavit of Domestic Partnership', in accordance with the procedures established by the University.

  - Ex-spouse. Your ex-spouse may be covered under the Health, Dental, and Vision Plans, if:

    1. The ex-spouse was covered by the University's benefit plans immediately prior to divorce and
    2. Is subject to a court order regarding coverage.

    The court order must be provided to the Tufts Support Services (TSS) in a timely manner.

Note: An employee may only cover a Spouse or an ex-spouse (if they meet the guidelines noted above); you may not cover both a current Spouse and an ex-Spouse at the same time.

- Your children. The term "children" includes:

- Your biological children
- Your legally adopted children
- Your stepchildren who live with you full time in a regular parent-child relationship,
- Your foster child, and
- Any other child permanently living with you for whom you are the legal guardian.

- In general, a child may be covered to the last day of the month following child's 26th birthday.
  - Coverage is provided on a tax-favored basis, regardless of whether the child is married, qualifies as your federal tax dependent, or relies on you for financial support.

- If your child is disabled and over age 26, the child may be covered for Health, Dental, and Vision if the child meets the following criteria:
  - was enrolled when first eligible to participate and
  - is incapable of self-sustaining employment due to a disability

- Documentation may be required.

The specific benefit options provided under each benefit plan may contain additional eligibility requirements. Please refer to the booklets and other descriptive materials you receive from the benefit plan vendors for additional eligibility requirements.

Retiree Health Insurance Plan

You are eligible to participate in the Retiree Health Insurance Plan if at retirement, (i) you are at least age 60 and have at least 5 years of benefits eligible service, or (ii) your age plus years of benefits eligible service with the University equals at least 75. If you satisfy these requirements and were hired by the University before January 1, 1994, the University may contribute towards (i) your premiums if you are under age 65 or (ii) a Health Reimbursement Arrangement if you are age 65 or older and enroll in a plan offered through Via Benefits. Your Spouse/DP and eligible family members may be eligible for the Retiree Health Insurance Plan if you and they satisfy the requirements for Retiree Health Insurance Plan coverage. In general, you must enroll in the Retiree Health Insurance Plan within 31 days after the later of (i) your retirement date or (ii) attainment of age 65. Please refer to the Summary Plan Description for the Retiree Health Insurance Plan for further information regarding Retiree Health Insurance Plan coverage and eligibility rules.

Retiree Dental Benefits Plan

If you are eligible for the Retiree Health Plan, you may elect to purchase dental coverage for yourself and eligible family members through the Retiree Dental Benefits Plan. You must enroll yourself and any eligible family members within 31 days of your retirement date. Please refer to the Summary Plan Description for the Retiree Dental Benefits Plan for further information regarding Retiree dental coverage.

Tufts University-Funded Retirement Plan - 401(a)

You are eligible to participate in the University-Funded Retirement Plan as of your first date of employment if you are at least 21 years old, have a Social Security Number or Individual Tax Identification Number, and are one of the following:

- an exempt or non-exempt employee regularly scheduled to work 17.5 hours or more a week; or a faculty member with at least a half time (as determined by the academic department), two-semester appointment; or

- a party to a job share contract (a job share contract is any contractual arrangement under which two employees, who each normally work at least 17.5 hours per week, fulfill the responsibilities of one job in accordance with the University's job sharing policy and all personnel policies and procedures then in effect).

If you are not age 21 or older on your first date of employment and meet the eligibility noted above, you will be eligible to participate in the University-Funded Retirement Plan as of the January 1 or July 1 next following the date you attain age 21.

Even if you are not in one of the eligible employee classifications listed above and are classified as a temporary employee, you may be eligible to participate in the University-Funded Retirement Plan on the date you complete one year of service for eligibility purposes or, if later, the January 1 or July 1 after you reach age 21. See the section entitled *Service Computation Rules – Eligibility* below for more information.

You are **NOT** an Eligible Employee and may **NOT** participate in the Plan if you are: (1) an employee covered by a collective bargaining agreement unless the agreement provides for participation; (2) an individual employed by the University who is in a division, department, unit, or job classification that the University designates as ineligible to participate in the University-Funded Retirement Plan; (3) a person performing services pursuant to an arrangement with a leasing organization, including but not limited to a "leased employee" within the meaning of Section 414(n) of the Internal Revenue Code; (4) an independent contractor or other person who is not treated by the University as an employee for purposes of withholding federal employment taxes, regardless of any contrary governmental or judicial determination relating to such employment status or tax withholding; (5) a Postdoctoral employee; (6) an employee hired for a special project or a special position not expected to last longer than 6 months; (7) an employee whose primary affiliation with the University is as a student (whether undergraduate or graduate); (8) an employee without a Social Security Number or Individual Tax Identification Number; or (9) a nonresident alien with no earned income from Tufts that is U.S. source income or an employee working outside of the U.S. with an offer of employment letter or employment agreement that states you are not eligible to participate in the University-Funded Retirement Plan.

Service Computation Rules – Eligibility

For purposes of eligibility to participate in the University-Funded Retirement Plan, a *year of service* is a 12- consecutive-month period during which you complete a minimum of 1,000 hours of service (generally each hour for which you are paid for work, including paid absences). The initial computation period will be the 12 months starting with your date of hire (or date of rehire after a period of severance of at least one year). Thereafter, a year of service will be computed based on the plan year (January 1 to

December 31) commencing with the plan year that begins after your date of hire.

Tufts University Self-Funded Retirement Plan – 403(b)

All employees of Tufts University (excluding student employees whose earnings are not subject to FICA and nonresident aliens with no earned income from Tufts that is U.S. source income) are eligible to participate in the Self-Funded Retirement Plan.

ENROLLMENT AND ELECTIONS

You may elect any available option under the University's benefit plans by enrolling when you are first eligible. In addition, you must authorize the University to deduct from your pay your share, if any, of the cost of coverage you elect.

Initial Enrollment

With the exception of the University-Funded Retirement Plan, the Self-Funded Retirement Plan, the Business Travel Accident Insurance Plan, and Long Term Care, in order to participate, you must enroll in the University's benefit plans within 31 days of the date when you are first eligible. You may obtain enrollment information by contacting Tufts Support Services (TSS). Your elections with respect to health, dental, vision, flexible spending accounts, life insurance, AD&D, and long term disability insurance under the respective Plans will be effective on the date you are first eligible.

Effective January 1, 2017, new hires and newly eligible employees will be automatically enrolled in the 60% option for the long term disability insurance benefit. You may change the election to the 40% disability option of or waive coverage during your initial enrollment period or in any subsequent annual Open Enrollment Period.

Note: If you are not actively at work on the date coverage takes effect, coverage for you and your eligible dependents is delayed until you return to active employment. This is also true for changes in coverage, so that a change in coverage generally will not be effective until a return to active employment status. However, if you are not actively at work due to a health condition, you will be treated as actively at work for purposes of all group health benefits.

When you enroll in the Health, Dental or Vision Plans, you may elect individual, two-person, or family coverage. If you elect individual coverage, only you will be covered. If you elect two-person coverage, you and one eligible dependent will be covered. If you elect family coverage, you and all of your eligible dependents for whom you have requested coverage will be covered.

If you do not enroll within 31 days of the date you are first eligible, you will not be able to enroll until the next annual open enrollment, unless you experience a qualified status change event.

Employees do not enroll in the Reduction in Force Policy. Instead, an employee becomes eligible for benefits under the Policy if they experience an involuntary termination of employment due to a reduction in force and satisfies other requirements for benefits. The Plan Administrator will advise an employee if they become eligible for benefits under the Policy.

Annual Open Enrollment

During the University's annual open enrollment (usually during October/November) you will be given the opportunity to review and make changes to your elections for the next plan year (calendar year). Any changes you make to your elections during open enrollment will be effective January 1 of the next plan year. Your benefit elections generally will remain in effect from year to year until you change them, but you must renew your Flexible Spending Account elections each year during open enrollment. In addition, your benefit elections for a plan year usually cannot be changed until the next annual open enrollment.

However, if you experience an event during a plan year that is a qualified change in status recognized by federal law, you may change your elections in a manner that is consistent with that event for the remainder of the plan year. See the section entitled *Changes to Your Elections* for more information.

Special Enrollment Rights

If you do not enroll yourself and your eligible dependents in the Tufts University group Health Plan when you first become eligible or during the annual Open Enrollment, you may be able to enroll under the special enrollment rules under HIPAA that apply when an individual initially declines coverage and later wishes to elect it.

Generally, special enrollment is available if: (i) you initially declined coverage because you had other health care coverage that you have lost through no fault of your own (e.g., not because of nonpayment of premiums); or (ii) since declining coverage initially, you have acquired a new dependent (through marriage, or the birth/adoption/foster placement of a child) and wish to cover that person. In the former case, you must have given (in writing if a written statement was required at the time by the Plan Administrator and you were provided with a notice of that requirement and its consequences at that time) the alternative coverage as your reason for waiving coverage under the Health Plan when you declined to participate. In either case, as long as you meet the necessary requirements, you can enroll both yourself and all eligible dependents in the corresponding Tufts University Health Plan within 31 days after you lose your alternative coverage or the date of your marriage or the birth, adoption, or placement for adoption of your child. In the event of an acquisition of a child, you may elect retroactive coverage to the date of birth/ adoption/ foster placement of the child.

Effective January 1, 2015, you may prospectively revoke coverage under the Tufts University Health Plan to enroll in a qualified health plan offered through the Marketplace if: (i) you experience a change in employment status that causes your hours to fall (on average) below 30 hours per week (or the equivalency of 30 hours if you are not paid on an hourly basis); or (ii) you enroll in a qualified health plan offered through the Marketplace pursuant to its open enrollment period or a special enrollment period designated under federal law. The "Marketplace" is where you can purchase a qualified health plan under Health Care Reform.

By law, the special enrollment opportunities described in this section and the next three sections of this booklet apply only to the Health Plan, and not to the Dental Plan, Vision Plan, the Employee Assistance Plan, or the Flexible Spending Account Plans. They also do not apply to the Retiree Health and Retiree Dental Plans. The University has decided to extend comparable special enrollment opportunities, however, to employees and their eligible dependents under the Dental and Vision Plans. Accordingly,

the special enrollment rules, procedures, and deadlines described in this section apply to the Dental and Vision Plans. In addition, you may be eligible to enroll yourself and an eligible dependent or make other changes to your benefit elections under the Health, Dental, Vision, and Flexible Spending Account Plans if you have a qualified change in status. Please refer to the *Changes in Your Elections* section later in this booklet for more information.

Children's Health Insurance Program Reauthorization (CHIP)

The Children's Health Insurance Program Reauthorization Act ("CHIP") provides two (2) special enrollment opportunities for Participants and their dependents under the Tufts University Health Plans.

First, if you, your Spouse, or dependent lose eligibility for assistance under a state CHIP program or Medicaid coverage, then you may be able to enroll yourself if you lose assistance, or your Spouse or dependent if they lose assistance, in a University Health Plan, provided your completed benefit election form is received by Tufts Support Services within **60 days** after the loss of CHIP or Medicaid coverage.

Second, if you become eligible for premium assistance under a state CHIP program or Medicaid, then you may enroll yourself if you become eligible for assistance, or your Spouse or dependent if they become eligible for assistance, in a University Health Plan, provided your completed benefit election form is received by Tufts Support Services within **60 days** of the determination of eligibility for assistance.

Qualified Medical Child Support Orders (QMCSO)

A Qualified Medical Child Support Order ("QMCSO") is an order by a court for one parent to provide a child or children with health benefits coverage under a University Plan. The Plan Administrator will comply with the terms of any qualified medical child support order it receives and will:

- Establish reasonable procedures to determine whether medical child support orders are qualified medical child support orders as defined under Section 609 of ERISA;

- Promptly notify you and any alternate recipient (as defined in Section 609(a)(2)(C) of ERISA) of the receipt of any medical child support order, and the Health Plan's procedures for determining whether medical child support orders are qualified medical child support orders; and

- Within a reasonable period of time after receipt of such order, the Plan Administrator will determine whether such order is a qualified medical child support order and will notify you and each alternate recipient of such determination.

Enrollment of Same-Sex Spouses and Domestic Partners (DPs)

Effective June 26, 2013, if you are legally married under the laws of a state that recognizes same-sex marriages, then your same-sex spouse will be treated as your legal Spouse under all benefit plans maintained by the University, regardless of the laws of the state in which you reside. Accordingly, you may enroll your same-sex spouse as your Spouse under all of the University's plans that provide coverage for Spouses, and their children will be treated as your stepchildren for purposes of determining if they may be enrolled in University plans as your qualified "children." In addition, your

same-sex spouse will be treated as your legal Spouse for all purposes under the University-Funded Retirement Plan and the Self-Funded Retirement Plan.

If you have registered a Domestic Partnership with Tufts Support Services (TSS), you may enroll your DP (and the eligible children, if any) for coverage under the University's group Health, Dental and Vision Plans, but you may not seek reimbursement for expenses incurred by your DP (and eligible children who are not your qualified "children") under the Flexible Spending Accounts and your DP will not be treated as your Spouse under the University-Funded Retirement Plan and Self-Funded Retirement Plan.

Tax Implications

Generally, contributions made by you for Health, Dental and Vision care, and Flexible Spending Account benefits for you, your Spouse, and dependent children may be made on a pre-tax basis under the University's cafeteria plan. Contributions made by the University on your behalf for these benefits are not included in your income and benefits provided under these benefit plans are not taxable benefits. There are, however, some instances where the value of coverage is taxed to you as income for federal and/or state purposes. These instances include the following:

- Effective June 26, 2013, if you are legally married under the laws of a state that recognizes same-sex marriages, then your same sex partner is your Spouse (and their children will be your stepchildren) under federal law regardless of where you reside. This means that you may make pre-tax contributions on behalf of your Spouse and stepchildren who qualify as your "children" or tax-dependents under the cafeteria plan (and be reimbursed for their expenses under the Flexible Spending Accounts), and the value of coverage provided to your Spouse and eligible stepchildren will not be treated as taxable income to you for federal tax law purposes. Whether the value of your benefits will be taxed under state law depends on the laws of the state in which you reside (*e.g.*, whether the state recognizes same-sex marriages for state tax law purposes). Massachusetts state law recognizes same-sex marriages. You should check with your tax advisor for further information.

If you are not legally married, then you may make pre-tax contributions towards the coverage of your DP and your partner's children and the value of their coverage may be excluded from your income if they qualify as your dependents for income tax purposes (or if your partner's children otherwise are your qualified "children"). If they do not qualify as your dependents or qualified "children" for income tax purposes, the value of their coverage may be considered income to you for both federal and state tax law purposes and you may not make any pre-tax contributions on their behalf to any plan. You must pay for their coverage on an after-tax basis. Please see the explanation of tax implications of imputed income below.
If you are not legally married, but are a resident of a state that allows for the registration of your relationship as a civil union or a domestic partnership, the value of any coverage provided to your DP may be taxable under federal tax law, but may not be taxable under state tax law. You may not make any pre-tax contributions on their behalf to any plan; you must pay for their coverage on an after-tax basis. Please see the explanation of "imputed income" below.

- **You may also refer to *Answers to Frequently Asked Questions for Individuals of the Same Sex Who Are Married under State Law* at http://www.irs.gov/uac/Answers-to-Frequently-Asked-Questions-for-Same-Sex-Married-Couples.**

- If you are covering your ex-spouse pursuant to a court order, you may make pre-tax contributions towards the coverage of your ex-spouse and the value of their coverage may be excluded from your income if they qualify as your dependent for income tax purposes. If your ex-spouse does not qualify as your dependent for income tax purposes, then you may not make any pre-tax contributions on their behalf to any plan. You must pay for your ex-spouse's coverage on an after-tax basis and the value of their coverage may be considered imputed income to you for both federal and state tax law purposes. Please see the explanation of imputed income below.

The additional income that you may receive for covering a DP, your DP's children, or an ex-spouse is known as "imputed income." If you are subject to imputed income, it will be shown on your pay statement and Form W-2 Wage and Tax Statement for the year in which coverage was effective. You will be required to pay taxes on this additional income, as required by the Internal Revenue Code and state tax law, if applicable.

This document does not address federal, state and local tax treatment in detail, and is not intended to provide tax advice. **For information on how applicable tax laws may apply to your personal situation, consult your tax adviser.**

CHANGES TO YOUR ELECTIONS

Health, Dental, Vision, and Flexible Spending Account Elections

Generally, federal law prohibits changes to your elections for Health, Dental, Vision, and Flexible Spending Account benefits during the plan year. However, you may make a change to your election if you have a qualified change in status (as described below) and the election change is on account of and consistent with the change in status. To change your elections, you must notify Tufts Support Services (TSS) within **31 days** of the change in status and provide any proof of the change as may be required by the University; otherwise, you will be required to wait until the next annual open enrollment.

Note: Any changes related to a Spouse or child(ren) will apply equally to a same-sex spouse, a DP, and the child(ren) of a same-sex spouse or DP.

The following events are considered changes in status for purposes of the Plan:

- Legal marriage (including a legal marriage under the laws of a state that recognize same-sex marriages and recognition of an existing same-sex marriage as a legal marriage under federal law following the repeal of the Defense of Marriage Act);
- Commencement of a DP relationship (as evidenced by filing of an Affidavit of Domestic Partnership, in accordance with the procedures established by the University);
- Divorce, legal separation or termination of a DP relationship (as evidenced by terminating an Affidavit of Domestic Partnership, in accordance with the procedures established by the University);
- Birth, adoption, or placement for adoption of your child or your child becoming ineligible for dependent coverage (*e.g.*, as an adult child);
- Death of a Spouse or DP or dependent;

- Your covered dependent reaches the age limit for coverage;
- A move out of your health plan's service area;
- You, your Spouse/DP or eligible dependent begins or returns from an unpaid leave of absence;
- You, your Spouse/DP, or eligible dependent has a change in job status that affects eligibility for coverage under a Tufts University benefit plan or a plan of your eligible dependent's employer;
- A significant increase or decrease (generally 25% or more) in the cost of coverage (or a coverage option) or a significant change in the coverage (or coverage options) offered under the Plan;
- Effective January 1, 2015, you become eligible to enroll in a qualified health plan through the Marketplace (i) due to a reduction in hours (below 30 hours a week on average or the equivalency of 30 hours if you are not paid on an hourly basis) or (ii) during an open enrollment period or a special enrollment period designated by federal law for enrollment through the Marketplace;
- Other events that will permit a change in your health coverage elections include (1) a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order or "QMCSO") that requires health coverage for your child or foster child, (2) you, your Spouse, or child becoming entitled to Medicare benefits; or (3) you, your Spouse, or child becoming entitled to a special enrollment right as discussed in the *Enrollment and Elections* section of this booklet;
- Any other events that the Plan Administrator determines would permit a change of election under applicable governmental regulations.

Your election change must be on account of and consistent with the change in status. Examples of the consistency requirement include:

- If a new health, dental, or vision benefit becomes available through the University (or an existing benefit is eliminated) during the plan year, or if a similar change occurs under a plan of your Spouse/DP or dependent's employer, you may elect the new coverage (or may elect another option if a coverage has been eliminated), and may make corresponding election changes regarding similar coverage for the balance of the plan year; however this does not apply to the Health Care Flexible Spending Account.
- If your share of the cost of Health, Dental, or Vision coverage, or daycare provider cost under the Dependent Care Flexible Spending Account, significantly increases or coverage is significantly curtailed, you may change your current election and elect similar coverage offered by the University for the balance of the plan year. Cost increases imposed by a daycare provider who is your relative are not considered significant and your Dependent Care Flexible Spending Account election cannot be changed for the balance of the plan year on account of such expense.

If permitted under the applicable insurance contracts, you may be allowed to change health insurance providers during the plan year. Normally, such a change may take place only during the annual Open Enrollment Period prior to each plan year. However, you may be permitted to change providers where there has been a significant change in the cost or coverage level of your or your Spouse's health

coverage during the plan year, as determined by the University.

When Changes are Effective

If you experience a qualified change in status and you want to change your Health, Dental, Vision, or Flexible Spending Account elections, you must complete the appropriate form and submit it to Tufts Support Services (TSS) within **31 days** of the change in status. The election change will be effective the date Tufts Support Services (TSS) receives the completed form and supporting documentation, except in the case of birth, adoption, and placement for adoption, in which case the effective date of the election change is the date of the event.

All election change requests received more than 31 days after the change in status will not be processed. **To change an election after this 31-day period, you will have to wait until the next annual Open Enrollment Period or another change in status, whichever occurs sooner.**

To learn what specific election changes are allowable given a particular change in status, or to initiate an election change during the plan year, please contact Tufts Support Services (TSS). Please note that the Plan Administrator reserves the right to review and interpret all requests for changes to elections due to a change in status.

Other Elections

Life Insurance, Accidental Death and Dismemberment (AD&D), and Long Term Disability Insurance

You may change your supplemental life, dependent life, AD&D, and long term disability insurance benefit elections during the annual Open Enrollment Period. In addition, you may change your supplemental life and dependent life insurance if you experience a qualified status change that relates to one of the following events:

- Events that change your legal marital or Domestic Partnership status (including marriage, commencement of DP relationship (as evidenced by filing an Affidavit of Domestic Partnership), divorce, legal separation, annulment or the death of your Spouse, or termination of a DP relationship); or

- Events that change the number of your dependents (including birth, adoption or placement for adoption, or the death of a dependent, including a DP).

If you wish to increase such coverage, or enroll for the first time, you may be required to apply for and receive approval from the insurer. Please refer to the University's benefits website at https://access.tufts.edu/get-work-done/benefits-resources/benefits for more detailed information.

University Funded Retirement Plan – 401(a)

You may change your University-Funded Retirement Plan investment elections at any time. Changes to the investment of future contributions will be effective with the University's next contribution remittance to the Plan. Changes to the investment of your existing account balance will be effective as soon as administratively practicable following receipt of your election, subject to any restrictions

imposed by TIAA or Fidelity. Please refer to the *University-Funded Retirement Plan* section for further information.

Self-Funded Retirement Plan- 403(b)

You may change your Self-Funded Retirement Plan contributions and investment elections at any time. Your contribution changes will be effective the first day of the available payroll period following your election. Please refer to the *Self-Funded Retirement Plan - 403(b)* section for further information.

WHEN COVERAGE ENDS

Health, Dental, Vision, Flexible Spending Accounts, Life Insurance, AD&D, Long Term Disability Insurance and Long Term Care Insurance

Coverage for you and your dependents (if applicable) ends at 11:59 p.m. on the earliest of the following dates:

- the date you or your dependents are no longer eligible for coverage;
- the date you are no longer an eligible employee of the University;
- the date the benefit plan terminates;
- the date you or your dependents fail to pay for the cost of coverage;
- the date you or your dependents receive the maximum benefit from the benefit plan (annual and lifetime limits do not apply to essential health benefits offered under the Health Plan); or
- the date your or your dependent's election for coverage is terminated in accordance with the terms of the benefit plan.

Notwithstanding the above, the Plan Administrator may, in its sole discretion, cause the participation of you or your dependents in a benefit plan to terminate if you or your dependents provide false information or make misrepresentations in connection with a claim for benefits; permit a non-participant to use a membership or other identification card for the purpose of wrongfully obtaining benefits; or obtain or attempt to obtain benefits by means of false, misleading, or fraudulent information, acts, or omissions.

When your Health, Dental, Vision, or Health Care Flexible Spending Account coverage ends, you and your dependents may be eligible to elect to continue your coverage for an additional period of time. Please refer to the *COBRA Continuation Coverage* section later in this booklet for more information.

Tufts University-Funded Retirement Plan – 401(a)

Your active participation in the University-Funded Retirement Plan ends on the earliest of the following:

- the date of your death;
- the date of your retirement at or after your Normal Retirement Date (age 60);

- the date of your termination from employment for reasons other than death or retirement; or
- the date the University-Funded Retirement Plan terminates.

After your active participation ends and if you meet the vesting requirement for the University-Funded Retirement Plan, you will remain a Participant, albeit an inactive Participant, until your account is distributed.

Tufts University Self-Funded Retirement Plan – 403(b)

Your active participation in the Self-Funded Retirement Plan ends on the earliest of the following:

- the date of your death;
- the date of your retirement at or after your Normal Retirement Date (age 60);
- the date of your termination from employment for reasons other than death or retirement;
- the date the Self-Funded Retirement Plan terminates; or
- the date you cease to have a salary reduction agreement in effect under the Plan.

After your active participation ends, you will remain a Participant, albeit an inactive Participant, until your account is distributed.

Leaves of Absence

Except for the University-Funded Retirement Plan and the Self-Funded Retirement Plans, once you enroll in the University's benefit plans, you may continue to participate in the benefit plan(s) and receive benefits during an authorized leave of absence from your University employment. If you continue to be paid by the University during an authorized leave of absence, your contributions to the benefit plans, if any, will continue to be deducted from your salary before federal, state, and FICA taxes are withheld. If you will not be paid by the University during an authorized leave of absence, you will be required to pay your portion of the contributions directly to the University out of your own pocket either on a pre-tax or an after-tax basis under the terms of the benefit plan and/or the Cafeteria Plan.

Please note, however, that the Plan Administrator will continue coverage (including Health, Dental, Vision, and coverage under the Flexible Spending Account Plan) as required by law for any leaves of absence taken in accordance with the Family and Medical Leave Act of 1993 ("FMLA") or the Uniformed Services Employment and Re-employment Rights Act ("USERRA"). Any leave taken pursuant to FMLA or USERRA must be taken in accordance with those laws and with the University's personnel policies.

COST OF COVERAGE

Under the University's benefits plans, some benefits are fully paid by the University, some benefits are paid partly by you and partly by the University, and some benefits are fully paid by you. The University sets the level of any employee contribution. The University reserves the right to change the level of employee contributions at any time.

To the extent you pay for any of the benefits, in whole or in part, your contribution is made on a pre-tax or after-tax basis. Your contributions for health, dental, vision, and flexible spending account benefits under the respective Plans are made on a pre-tax basis. Your contributions for life insurance, AD&D, long term disability insurance, and long term care insurance benefits are made under the respective Plans on an after-tax basis. "Pre-tax" means that the cost of coverage will be deducted from your pay before federal income taxes, Social Security taxes and, in most cases, state or local income taxes are withheld. "After-tax" means that the cost of coverage will be deducted from your pay after federal income taxes, Social Security taxes, and state or local income taxes are withheld.

Contributions, both pre-tax and after-tax, are made by entering into a compensation withholding agreement with the University that authorizes the University to deduct the cost of coverage from your pay. You will authorize withholding and payment via a compensation withholding agreement when you enroll for your benefits. This authorization and withholding agreement may be in an electronic or paper format.

Exception: Unless your DP and their children qualify as your "dependents" for federal tax purposes (or your qualified "children"), your contributions towards their coverage for Health, Dental and/or Vision Plan benefits for may not be deducted from your pay on a pre-tax basis. The same rule also applies to an ex-spouse that is receiving one or more of these benefits pursuant to a court order. In addition, you are taxed on the full value of the University's contributions towards coverage for these individuals. Your contributions will be deducted from your pay on an after-tax basis and the University's contributions will be treated as taxable compensation received by you. In addition, you may not be reimbursed from your Flexible Spending Accounts for health or dependent care expenses incurred by or on behalf of your DP, their child(ren), or your ex-spouse if they do not qualify as your "dependents" for federal tax purposes.

Impact of Pre-Tax Elections on Other Benefits

Any benefits you pay for on a pre-tax basis will reduce your taxable income. Having a lower taxable income will result in your paying less in Social Security taxes and, consequently, you or your family may receive a slightly lower Social Security benefit at retirement. The savings through the payment of benefits on a pre-tax basis, however, are generally greater than any Social Security benefit reduction that might result.

Although any benefits you pay for on a pre-tax basis will reduce your taxable income, these pre-tax payments will not reduce the value of your benefits that are based on compensation (*e.g.*, the life insurance, AD&D, long-term disability insurance, or the University's contributions to the University-Funded Retirement Plan) as those benefits are based on a definition of compensation that includes your pre-tax payments.

BENEFITS

This section summarizes the benefits available under the benefit plans. For a more complete description of the benefits available under each benefit plan, please refer to the separate booklets and other descriptive materials that you receive from the University and benefit plan vendors.

HEALTH

Coverage Options

The University offers the following Preferred Provider Organization (PPO) health coverage options exclusively through Tufts Health Plan:

- Tufts University Quality Tiered Health Plan (PPO)
- Tufts University Traditional Health Plan (PPO)
- Tufts Value Health Plan (PPO)

Effective January 1, 2011 and thereafter, the lifetime maximum benefit will not apply to essential health services. In general, "essential health services" include: ambulatory care, hospitalization, emergency services, maternity and newborn care, rehabilitative and habilitative services and devices, mental health and substance abuse disorder services, prescription drugs, laboratory services, pediatric services, certain preventive and wellness services, chronic disease management, and such other services that the federal government deems to be essential health services. In addition, effective January 1, 2014, an annual limit will not apply on these essential health services. These rules apply only to the Health Plan, and not to the Dental, Vision, Employee Assistance Plan, or Flexible Spending Account Plans.

Once you are enrolled in a health coverage option, you will receive information about your specific health benefit coverage prepared by Tufts Health Plan. Your information is an official part of this document and has complete details about what is covered, including any limitations or exclusions that might apply. Keep this information so you can refer to it when you have questions about the University's Health Plan.

Paying for Coverage

You are required to contribute toward the cost of the health coverage you elect. The University determines the contribution you are required to pay each year.

Special Benefit for Maternity and Infant Coverage

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the attending provider or physician, 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 a plan or the issuer for prescribing a length of stay not in excess of 48 hours or 96 hours, as the case may be.

Special Benefit for Women's Health Coverage

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires group health plans (like the PPOs), insurance issuers, and health maintenance organizations (HMOs) who already provide health and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery

following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (iii) prostheses and physical complications at all stages of mastectomy, including lymphedemas. These procedures may be subject to annual Deductibles and coinsurance provisions that are similar to those applying to other health or surgical benefits provided under the Health Plan. For answers to specific questions regarding WHCRA benefits, contact the Plan Administrator. Additional state laws may be applicable as more fully described in other materials detailing your health benefits.

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects Americans against discrimination based on their genetic information when it comes to health insurance and employment.

Mental Health Parity (MHPA)

The Mental Health Parity Act ("MHPA"), as amended, requires that the annual or lifetime dollar limits on mental health benefits may not be lower than any such dollar limits for health and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan. The lifetime limit ceased to apply effective January 1, 2011 and the annual limit ceased to apply effective January 1, 2014. Federal law also requires that plans providing mental health and/or substance abuse benefits and health/surgical benefits to provide the same level of benefits and services. For example, a plan providing both health/surgical and mental health benefits may not impose more restrictive financial requirements (such as Deductibles and copayments) and treatment limitations (such as limits on days of coverage) on mental health benefits than are imposed on health/surgical benefits.

Michelle's Law

Michelle's Law was signed into law effective January 1, 2010. This law amends the Employee Retirement Income Security Act (ERISA) to allow seriously ill or injured full-time college students, who are covered under their parent's health insurance plan, to take up to one year of medical leave without losing their health insurance.

Continuation Coverage for Employees in Military Service (USERRA)

Under USERRA, if you leave your job with Tufts University to perform military service (with the armed forces of the United States), then you may be entitled to continue coverage under the Health Plan for you and your dependents. The coverage period ends after 24 months or, if earlier, when you fail to apply for reinstatement or return to employment with Tufts University within the time periods required by USERRA.

If your military service is 30 days or fewer, then you will pay the ordinary employee premium for coverage. If military service exceeds 30 days, then you must pay the applicable COBRA premium to continue your coverage. USERRA continuation coverage and COBRA continuation coverage run concurrently. If you continue coverage for 24 months under USERRA, then 24 months of COBRA continuation coverage will be exhausted. In general, the administrative policies and procedures described for COBRA continuation coverage also apply to USERRA continuation coverage.

If you return to employment with Tufts University following military service, you may be reinstated in the Health Plan, generally without any waiting periods or exclusions (*e.g.*, pre-existing condition exclusions) except for military service-connected illnesses or injuries.

Please contact Tufts Support Services for additional information if USERRA may affect you.

Cleft Palate and Cleft Lip Services

Effective January 1, 2013, a child under the age of 18, who is covered under the Health Plan will be provided coverage for treatment of cleft lip and cleft palate.

Hearing Aids for Children

Effective January 1, 2013, a child 21 years of age or younger, who is covered under the Health Plan will be provided coverage for treatment for the full cost of one (1) hearing aid per hearing impaired ear up to two thousand dollars ($2,000) for each hearing aid, as defined under section 196 of chapter 112, every 36 months upon a written statement from such minor's treating physician that the hearing aids are medically necessary.

Health Care Reform

Health Care Reform made several changes in the laws that affect health plans effective January 1, 2011 and January 1, 2014. In addition, the Tufts University Health Plan became subject to additional changes made by Health Care Reform effective January 1, 2015 when it stopped being a "grandfathered plan." These changes apply only to the Health Plan, and not to the Dental Plan, Vision Plan, Flexible Spending Account Plans, or the Employee Assistance Plan.

- Adult Children. You may cover your adult children ages 19 through 25 in the Health Plan regardless of whether they reside with you, are married, are eligible for other health coverage, or depend on you for support; please refer to pages 6-7 and Appendix B of this booklet.

- Lifetime and Annual Dollar Limits. The Health Plan will not apply lifetime limits on the dollar value of essential health benefits. Annual limits were phased out as of January 1, 2014. Essential health benefits generally include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, and pediatric services.

- No Rescission of Coverage. Once you become covered under the Health Plan, your coverage (or your dependent's coverage) may not be canceled **retroactively** unless you (or your dependent) have engaged in fraud, made an intentional misrepresentation of material fact, or failed to make timely contributions for coverage.

- No Discrimination Based on Health-Related Factors. Effective January 1, 2014, the Health Plan will not discriminate against any participant or dependent in terms of eligibility to participate in the Plan based on health-related factor. In addition, benefits provided under the Health Plan will be available to all similarly situated individuals. Any restriction on benefits will be applied uniformly to all similarly situated individuals and may not be directed at an individual based on a health-related factor. The Health Plan may (i) limit or exclude benefits that are experimental or

are not medically necessary and (ii) require an individual to satisfy a Deductible, copay, coinsurance, or other cost-sharing requirement in order to obtain a benefit, provided that all limits, exclusions, or cost-sharing requirements apply uniformly to all similarly situated individuals, and are not just directed at an individual based on a health-related factor.

- No Waiting Period Longer than 90 days. Effective January 1, 2014, the Health Plan will not impose a waiting period longer than 90 days for Plan participation. The 90-day limit isn't breached if you take additional time to elect coverage at the end of the 90-day waiting period or decide not to enroll.

- Coverage for Preventative Services. Effective January 1, 2015, certain preventive services for adults, children, and pregnant women provided by an in- network provider are covered at 100% without any co-payment or Deductible. In general, these preventative services include screening for various illnesses, immunizations, and counseling for various conditions.

- Women's Preventive Health. Effective January 1, 2015, preventive health services, such as mammography and cervical cancer screenings, are covered at 100% without any co-payment or Deductible. In addition, the Plan covers contraceptives, breastfeeding supplies, and counseling on cancer and breastfeeding.

- Primary Care Provider/Referrals. Effective January 1, 2015, you may choose your primary care provider in-network. A child may choose a pediatrician as a primary care provider. A woman may select a health care professional specializing in obstetrics or gynecology. In addition, you may visit any in-network physician or health care provider without a referral from your primary care physician.

- Pre-authorization Not Required for Out-of-Network Emergency Services. Effective January 1, 2015, the Tufts University Health Plan will cover emergency services (as defined under Health Care Reform) without prior authorization, regardless of whether the services were provided in-network or out-of-network or furnished by a participating provider. The Tufts University Health Plan will charge the same co-payment and/or co-insurance applicable to in-network emergency services.

- Coverage for Routine Costs of Clinical Trials. Effective January 1, 2015, medically necessary routine patient care costs in clinical trials relating to the prevention, detection, or treatment of cancer or another life-threatening disease or condition will be covered under the Tufts University Health Plan, provided it is (i) federally funded or approved, (ii) conducted under an FDA investigation new drug application, or (ii) exempt from the requirement of an FDA investigational new drug application. The Tufts University Health Plan may require participation in a clinical trial through a participating provider if the provider will accept the Participant in the trial. If provided out-of-network, then all applicable Plan limitations for coverage of out-of-network care will apply. The Tufts University Health Plan will not discriminate against an individual for participating in an approved clinical trial.

- Out of Pocket Maximums. Effective January 1, 2017, the out of pocket maximums for the Tufts University Health Plan may not exceed $7,150 for an individual (regardless of whether the individual is covered under single or family coverage) and $14,300 for a family for covered essential services. Effective January 1, 2018, the out of pocket maximums will increase to $7,350

for an individual and $14,700 for a family for covered essential services. The cost sharing amounts counted toward the out of pocket maximums include Deductibles, co-insurance, and co-payments. The Health Plan is not required to count premiums, amounts charged above the usual, customary, and reasonable amount, the cost of brand prescription drugs over the cost of generic drugs, balance billing amounts for out-of-network providers or other out-of-network cost-sharing, and the cost of non-essential health benefits toward these limits. Once the out of pocket maximums have been met, the Tufts University Health Plan pays 100% of the cost of covered essential benefits.

- Claims Procedures for Health Plan. The claims procedures in the section called "*Claims and Appeals*" have been revised effective January 1, 2015 to include new internal appeals and an external review process with respect to the Tufts University Health Plan.

Pre-existing Conditions/Certification of Health Coverage

Effective January 1, 2014, Health Care Reform makes it illegal for a health plan to impose a preexisting condition exclusion or limitation on any person who is covered under a health plan. The Tufts University Health Plan has not imposed any exclusion or limitation for preexisting conditions. However, Tufts has provided Participants and dependents with evidence of coverage under the Tufts University Health Plan so that they could (i) reduce a preexisting condition exclusion period under another plan, (ii) support special enrollment in another plan, or (iii) obtain certain types of individual health coverage even if the Participant or dependent has health problems. This evidence was called a certificate of creditable coverage and was provided after an individual's coverage under the University's Health Plan ended. Due to the change made by Health Care Reform, the University is not required to count creditable coverage for the plan year beginning on January 1, 2014 and subsequent years. In addition, the University's obligation to provide certificates of creditable coverage ended on December 31, 2014.

Please note that the prohibition on exclusions and limitations for preexisting conditions does not preclude the Tufts University Health Plan from excluding coverage for a specific condition or treatment, provided the exclusion (i) is not based on the fact that the condition was present before the effective date of coverage, (ii) does not exclude coverage for an essential benefit, or (iii) is not otherwise prohibited by law.

Health Coverage for Long Term Disability Claimants

Qualified long term disability claimants may retain Health Plan coverage through the University's active employee plan until reaching normal Social Security Retirement Age, unless they cease being disabled. If the employee was covered by a Tufts University Health Plan at the date the employee is deemed disabled, the University pays the full cost of this coverage. Please contact Tufts Support Services (TSS) regarding other benefits while on long term disability.

Continuation of Health Coverage under COBRA

When your health coverage ends, you and your eligible dependents may be eligible to elect to continue your coverage for an additional period of time. Please refer to the *COBRA Continuation Coverage* section later in this booklet for additional information.

Available Resources

Access Tufts Website

The Human Resources Benefits pages on Access Tufts is designed to provide you with details about your plans and provides direct links to plan vendors.

Tufts Support Services
62R Talbot Ave
Somerville, MA 02144
Phone: 617-627-7000
Fax: 617-627-7001
E-mail: tss@tufts.edu
Website: https://access.tufts.edu

For information on physician selection, Health plan coverage, or claims contact:

Tufts Health Plan
844-516-5790
https://tuftshealthplan.com/microsites/tufts-university

Provider Directories/Listings

Provider directories/listings for the applicable health provider networks utilized by the Health Plan can be accessed online; you can determine if your physician or provider participates in the University's Health Plans by checking the directory of participating providers on the website listed above. You also have the right to receive a printed provider list.

DENTAL

Coverage Option

The University offers a dental coverage option administered by Delta Dental Plan of Massachusetts. The Dental Plan allows you and your eligible dependents to choose the coverage you need and provides comprehensive benefits regardless of which dentist you choose. The three available provider options for dental benefits are:

- *The Delta Premier USA* Network;
- Tufts School of Dental Medicine Dental Clinic
- Out-of-Network.

Regardless of which provider option you choose, the plan provides a maximum benefit of $1,500 per calendar year per covered individual. Refer to the booklets and other descriptive materials you receive from the University and the benefit plan vendors for more information.

The following highlights the differences among the options.

Delta Premier USA – In-Network

When you choose to receive dental care through an in-network provider, you will receive:

- 100% coverage for up to two cleanings per year (every 6 months);
- 80% coverage for basic restorative services (after Deductible* is met);
- 60% coverage for major restorative services (after Deductible* is met);
- 50% coverage for orthodontia to any age (up to a lifetime maximum of $1,000).

*Calendar year Deductible of $50 per covered individual, $100 for 2-person coverage, up to $150 per family, applies to basic restorative services, major restorative services, and orthodontia.

In-network dentists generally accept reduced fees for services. Since your co-payment is based on these reduced fees, your out-of-pocket costs will reflect the discount. Your dentist will submit all claims for you and your eligible dependents directly to the Dental Plan. There are no claim forms for you to complete. The dentist is paid directly by the Dental Plan, therefore you do not have to pay the dentist up front and wait for a reimbursement check.

It is likely that your dentist is an in-network provider since 97% of the dentists in Massachusetts participate. Also note: Tufts Dental School faculty members are participating in-network dentists.

Provider directories/listings for the network utilized by the Dental Plan can be accessed online; you can determine if your dentist or provider participates in the Dental Plan by checking the Directory of Participating Dentists on the Delta Dental website at www.deltadentalma.com. You also have the right to receive a printed provider list.

In addition, you can find out if your dentist participates in the network by asking your dentist or by calling the Customer Service Department of Delta Dental at 800-872-0500.

Tufts School of Dental Medicine Dental Clinic

At the School of Dental Medicine Clinic, faculty-supervised students provide a full range of dental services.

When you choose to receive dental care through the School of Dental Medicine, you will receive:

- 100% coverage for up to three cleanings per year;
- 90% coverage for basic restorative services (no Deductible);
- 80% coverage for major restorative services (after Deductible** is met);
- 50% coverage for orthodontia to any age (up to a lifetime maximum of $1,000).
- 20% discount off services rendered to a Tufts University employee only on the balance after insurance benefits have been applied. Note: This discount does not apply to spouses, DPs or dependents who are not Tufts University employees.
- 20% discount for dependent child (up to age 26) of a Tufts University employee who receives treatment in the School of Dental Medicine Orthodontics Clinic. This discount is applied to the patient balance after insurance benefits have been applied.

**Calendar year Deductible of $50 per covered individual, $100 for 2-person coverage, up to $150 per family, applies to major restorative services and orthodontia only.

Out-of-Network

When you choose to receive dental care through an out-of-network provider, you receive:

- 100% coverage for up to two cleanings per year (every 6 months);
- 80% coverage for basic restorative service (after Deductible*** is met);
- 60% coverage for major restorative services (after Deductible*** is met);
- 50% coverage for orthodontia to any age (up to a lifetime maximum of $1,000).

***Calendar year Deductible of $50 per covered individual, $100 for 2-person coverage, up to $150 per family, applies to basic restorative services, major restorative services, and orthodontia.

However, in addition to your copayments and Deductibles, you are responsible for the difference between the Dental Plan payments and what the non-participating dentist charges. In Massachusetts, you will be reimbursed up to 80% of the median charge for the state of Massachusetts, or the dentist's charge, whichever is less. When you use an out-of-network, out-of-state dentist you will receive reimbursement based on the customary fee for the geographic area or the dentist's fee, whichever is less. You may be responsible for making payment to the dentist and submitting a claim for reimbursement to the Dental Plan.

See the section of this booklet entitled *Changes to Your Elections* for rules governing your ability to change your dental election.

Rollover Maximum Program

Under this program, members can save and accumulate part of their unused dental benefit dollars from a given year and use them for larger, more expensive procedures in the future. A brochure outlining the specific details of this program is available online on the Tufts University Benefits website at https://access.tufts.edu/get-work-done/benefits-resources/benefits

Paying for Coverage

You are required to contribute toward the cost of the dental coverage you select. The University determines the contribution you are required to pay each year.

Continuation of Dental Coverage under COBRA

When your dental coverage ends, you and your eligible dependents may elect to continue your coverage for an additional period of time. Please refer to the *COBRA Continuation Coverage* section later in this booklet for additional information.

No Conversion of Dental Coverage

If your employment terminates, you may not convert your group dental coverage to an individual policy.

Dental Plan Continuation Coverage for Employees in Military Service

You may be entitled to continue your coverage under your Dental Plan if you leave your job to perform qualified military service under USERRA. Please refer to the *Continuation of Coverage for Employees in Military Service (USERRA)* section in this booklet for additional information.

VISION

Tufts University's Discount Vision Care Plan is administered by EyeMed Vision Care. You and your eligible family members may enroll in the Plan that is designed to encourage you to maintain your vision health through regular eye examinations and to help with vision care expenses. The Plan provides benefits for an annual eye examination and significant discounts on frames, lenses, contact lenses, lens accessories, LASIK and PRK Vision Correction Procedures.

EyeMed's provider network allows you to choose the best provider to meet your vision needs from a national network of optometrists, ophthalmologists, opticians and many leading optical retailers such as LensCrafters, Target Optical and most Pearle and Sears Vision locations.

You will find a schedule of vision care discounts and services online on the Tufts University Benefits website at https://access.tufts.edu/get-work-done/benefits-resources/benefits. You may also contact EyeMed for information about your benefits or participating providers, at 866-9EYEMED or online at http://www.eyemedvisioncare.com. You may request a printed provider list.

Paying for Coverage

You are required to pay the cost of the vision coverage you select. The University determines the contribution that you are required to pay each year. You pay the full cost of the plan on a pre-tax basis.

Continuation of Vision Coverage under COBRA

When your vision coverage ends, you and your eligible dependents may continue your coverage for an additional period of time. Please refer to the *COBRA Continuation Coverage* section later in this document for additional information.

Vision Plan Continuation Coverage for Employees in Military Service

You may be entitled to continue your coverage under your Vision Plan if you leave your job to perform qualified military service under USERRA. Please refer to the *Continuation of Coverage for Employees in Military Service (USERRA)* section in this booklet for additional information.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts ("FSAs") provide valuable benefits designed to give you a way to reimburse yourself on a tax-free basis for certain health care and dependent care expenses. The Health Care FSA is designed to help you pay certain health care expenses that you and your family may incur. The Dependent Care FSA is intended to qualify as a dependent care assistance benefit within the meaning of

Section 129 of the Internal Revenue Code (the "Code") and help you pay certain qualified dependent care expenses that you and your family may incur. You may reimburse expenses incurred by you, your Spouse, your children, and other individuals that qualify as your dependents under the Internal Revenue Code (individuals that you claim as dependents on your federal income tax return).

Before the plan year begins, or when you first meet the eligibility requirements for the FSAs, you may elect to have a portion of your pay placed in either or both FSAs on a pre-tax basis. You estimate the amounts that you will require in each account for the year and divide the result by the number of pay periods left in the year. This equal amount will be deducted from your gross pay each pay period ***before taxes.*** For each FSA, per IRS rules you may designate an amount not in excess of **$5,000 for the Dependent Care FSA (which may be reduced as discussed below) and $2,700 for the Health Care FSA for 2019 per plan year**. This benefit allows you to use "untaxed" money to pay for services that you would otherwise pay for with after-tax dollars. **Health Care and Dependent Care reimbursements cannot be provided for expenses incurred prior to your hire date or the date that you become a Participant in the FSAs.**

Remember, it is important that you be ***conservative*** when estimating your expenses for the next plan year. IRS regulations state that any money set aside in a Dependent Care FSA not used for expenses incurred during the same year must be ***forfeited. ANY UNUSED DOLLARS CANNOT BE RETURNED TO YOU.*** This is known as the "use it or lose it" rule and is required by the IRS. The use it or lose it rule generally applies to the Health Care FSA as well, but IRS guidance permits you to carry over up to $500 in unused Health Care FSA contributions into the next plan year, provided that you make a Health Care FSA election for the next Plan Year. The minimum annual amount for the Health Care FSA account is $100. Please see the section below entitled *Special Carry Over Rules for Unused Contributions* for more information.

Please note that you will not be entitled to receive interest or any other earnings on contributions allocated to your FSA(s).

In summary:

- dollars you place in your account are taken out of your pay ***before*** federal and state taxes are withheld, which reduces your taxable income;
- the money in your account can only be used to reimburse eligible expenses incurred in the same plan year and only during the time during that year that you are enrolled in the FSA(s);
- you will not be entitled to receive interest or any other earnings on contributions made to your FSA(s);
- money in one account cannot be used to pay for items covered by the other account nor can money in one account be transferred to the other account;
- reimbursements are paid on a daily (business days only) basis or as reasonably soon thereafter following claim submission and review;
- active employees have until the **April 30** following the end of a plan year to submit claims to either account for expenses incurred during that plan year. If you terminate during the year, you

will have 120 days to submit claims incurred prior to your termination during that plan year; and

- child care applies to your dependents that are less than 13 years of age.

Here are a few other key considerations to keep in mind when evaluating and planning participation in your FSA:

- your eligible and predictable health care expenses;
- your eligible child care or elder care expenses;
- your gross income (including your Spouse's income) and tax bracket; and
- your ability to afford a reduction in your paycheck, since part of your pay is set aside for expenses.

Health Care Flexible Spending Account

The Health Care Flexible Spending Account (FSA) may be used to pay any health care expense that qualifies as a deduction under IRS rules, with the exception of premiums paid for other health plan coverage (including Medicare or plans maintained by the employer of your Spouse or dependent) and long term care insurance. The expenses covered must be "medically necessary" or prescribed by a licensed physician to qualify for reimbursement. Health care expenses reimbursed through your Health Care FSA cannot be claimed as an additional deduction for income tax purposes.

You can use the Health Care FSA to reimburse yourself for health care expenses incurred by you, your *Spouse** and your eligible dependents, which include your Spouse, qualified child(ren), and other individuals who qualify as your dependents for federal income tax purposes.

- A "Qualified Child" is a child who is your biological child, adopted child, stepchild, or foster child who is younger than age 26, regardless of whether they are married, lives with you, is eligible for other coverage, or is dependent on you for support.

For purposes of these determinations, special support and residency rules apply for separated or divorced parents. Contact your tax advisor for more information.

**In addition, for purposes of the FSAs, the term "Spouse" includes a same-sex spouse if you are legally married under the laws of a state that recognizes same-sex marriages, but it does not include a DP. The expenses of a DP may not be reimbursed unless the partner is your dependent for federal income tax purposes. The expenses of a child of a DP may not be reimbursed unless the child is your "Qualified Child" or dependent for federal income tax purposes.*

Eligible Health Care Expenses

Examples of health care expenses include, but are not limited to:

- Deductibles and co-payments;
- health care expenses not covered by any insurance;
- dental expenses not covered by any insurance;
- vision expenses not covered by any insurance;

- prescription drug expenses not covered by any insurance;
- smoking cessation programs, prescription drugs, over-the-counter gum or patches;
- ambulance and emergency health services;
- chiropractic office visit or treatment;
- contact lenses, cleaning solutions;
- bandages;
- flu shots;
- hearing aids and batteries;
- wheelchairs and repairs;
- prosthesis; health equipment and medical devices (for treatment of health condition) and repairs; and
- drugs purchased with a prescription (regardless of whether they are available without a prescription).
    - Over-the-counter medicines and drugs can be reimbursed only if prescribed by a physician. This requirement does not apply to insulin, even if purchased without a prescription.

Ineligible Health Care Expenses

In general, any expenses that cannot be claimed as health care expenses for income tax purposes are not reimbursable. Ineligible health care expenses include, but are not limited to the following:

- premiums for health insurance or long term care insurance;
- cosmetic surgery (except in limited circumstances);
- electrolysis;
- nonprescription items (such as vitamins) that are merely beneficial for you or your dependent's general health;
- dental bonding and bleaching;
- services for which any insurance reimburses you;
- services for your general wellbeing that are not for the diagnosis, cure, mitigation, treatment, or prevention of a disease or for the purpose of affecting a structure or function of the body (*e.g.*, massage or other therapy not prescribed by a doctor); and
- services rendered before the starting date or after the ending date of your enrollment into the Health Care FSA.

Please refer to the EBPA website at www.ebpabenefits.com for specific information regarding eligible and ineligible health expenses.

Special Carry Over Rules for Unused Health Care FSA Contributions

If you are an active Participant in the Plan and have elected a Health Care FSA, you may carry over $500 of any amount remaining unused in your Health Care FSA to the following plan year, provided you elect a Health Care FSA for the following year. The amount carried over will not count against the $2,650 limit (indexed for inflation under IRS rules) for the following year. The unused amounts that are rolled over into the next plan year must be used to pay or reimburse Eligible Health Care Expenses described above. They may not be cashed out or applied towards any other benefit offered under the cafeteria plan. Unused amounts in excess of $500 are forfeited under the use it or lose it rule described above.

Please note that the Plan Administrator sets a minimum Health Care FSA amount for each plan year ($100 for 2019). Under IRS guidelines, you may carry over up to $500 of unused contributions in your Health Care FSA. Carryover balances less than $100 are subject to the minimum enrollment requirement.

The following Examples illustrates how the carry over rules work:

> **Example 1**: In November 2017, an eligible employee selects a salary reduction amount of $2,650 for 2018 under the Health Care FSA. By December 31, 2018, the employee's unused amount from the 2018 plan year is $800. On February 1, 2019, the employee submits claims and is reimbursed with respect to $200 of expenses incurred during the 2018 plan year, leaving $600 in unused Health Care FSA contributions for 2018. The employee may carry over $500 of the unused Health Care FSA amounts from 2018 to 2019. The $500 amount is not forfeited; instead, it is carried over to 2019 and is available to pay claims incurred in that year. If the employee elects a $2,600 Health Care FSA for 2019, $3,100 (that is, $2,600 + $500) is available to pay claims incurred in 2019. The remaining $100 in unused Health Care FSA amount for 2018 is forfeited.
>
> **Example 2:** Assume the same facts as in Example 1 and that the employee incurs and submits claims for expenses of $2,750 during the month of July 2019 and does not submit any other claims for 2019. The employee is reimbursed with respect to the $2,750 claim, leaving $350 as an unused amount from 2019 that may be carried over into 2020.
>
> **Example 3:** Assume the same facts as in Example 2, except that the employee submits and is reimbursed for $3,060 in 2019. The employee may not roll over the remaining unused $40 into the 2020 plan year, unless they elect at least a $100 Health Care FSA for 2020.

HEART Act Reservist FSA Distributions

The Heroes Earnings Assistance and Relief Tax of 2008 ("HEART Act") permits "qualified reservist distributions" a distribution of all or a portion of unused amounts in health FSAs belonging to reservists ordered or called to active duty as a reservist. To be eligible for a distribution, your active duty must be for a period of at least 180 days or for an indefinite period; your contributions for the year must exceed the reimbursements that you have received from your Health Care FSA as of the date of the distribution; and the distribution must be made between the date of the order or call and the last date that reimbursements from the Health Care FSA could otherwise be made for the plan year that includes the date of the order or call to active duty. If you receive a qualified reservist distribution, then you will forfeit the right to be reimbursed for expenses incurred on or after the distribution date. You may still submit for reimbursement expenses incurred before the distribution date, provided the dollar amount of the expenses does not exceed the dollar amount you elected to contribute to the Health Care FSA for the plan year **minus** the sum of the qualified reservist distribution and any prior reimbursements.

Continuation of FSA Coverage during Family and Medical Leave

If you take a leave under FMLA, then you may continue your Health Care FSA during your leave. If your FMLA leave is a paid leave, then you may contribute to your account on a pre-tax basis. If your FMLA leave is an unpaid leave, then you may contribute to your account (i) on a pre-tax basis before you begin your leave, (ii) on an after-tax basis while you are on leave, or (iii) on a pre-tax or after-tax basis when

you return from leave. In addition, you may choose to revoke your election to contribute to your Medical FSA while you are on FMLA leave and reinstate your election when you return from FMLA leave.

Continuation of Health Care FSA Coverage under COBRA

When your Health Care FSA coverage ends, you and your eligible dependents may be eligible to elect to continue your coverage for an additional period of time, provided you make contributions to the account on an after-tax basis. Please refer to the *COBRA Continuation Coverage* section in this booklet for additional information.

Health Care FSA Continuation Coverage for Employees in Military Service

You may be entitled to continue your coverage under your Health Care FSA if you leave your job to perform qualified military service under USERRA. Please refer to the *Continuation of Coverage for Employees in Military Service (USERRA)* section in this booklet for additional information.

Applicable Health Care Laws

The Health Care FSA is generally treated like other types of employer health plans under applicable law. As described above, it is subject to the continuation coverage rules for Family and Medical Leave, COBRA, and Military Service. It is also subject to HIPAA rules for privacy and security of your health information and to the rules relating to qualified medical support orders described in this booklet. Please refer to the sections entitled *Privacy of Health Information*, *Security of Health Information*, and *Qualified Medical Child Support Orders (QMSCOs)* in this booklet. It is exempt, however, from the special enrollment rules and changes imposed by Health Care Reform.

Dependent Care Flexible Spending Account

The Dependent Care FSA is designed to help you (the Participant) pay for day care services for certain dependents, as follows:

- your child (including your stepchild or eligible foster child), grandchild, brother, sister, stepbrother, or stepsister who is **under age 13** and is your tax dependent
- your legal Spouse who is physically or mentally incapable of caring for himself or herself and who resides in your household for more than one-half of the taxable year; or
- your other tax dependent that is physically or mentally incapable of caring for himself or herself, which may include elder care for an elderly parent or other individual.

For this purpose, your child or other dependent is your tax dependent if they (i) reside in your household for more than half of the year and (ii) receives more than half of their support from you. Expenses incurred for services **outside of your household** for a dependent that is not a child under age 13 may be reimbursed only if the dependent regularly spends at least 8 hours each day in your household. The determination of whether an individual is an eligible dependent is made on a daily basis and at the time services are performed. The child of divorced or separated parents is an eligible dependent only with respect to the custodial parent, regardless of which parent claims a dependency exemption.

To be eligible, the services must make it possible for you and your Spouse to work or to attend school on

a full-time basis. You may not be reimbursed for care for any period during which you are not working or in school on a full-time basis, except that you may be reimbursed for care while you are on a short-term leave, generally no more than two weeks, or on a day that you do not work, if you are a part-time employee and are required to pay on a weekly or longer basis. Any type of dependent care that you could legally claim if you were filing for credit on your income taxes is eligible for funding under the Dependent Care FSA.

To be eligible to use this account, you must be actively working during the time your eligible dependent(s) is (are) receiving care.

Qualifications for Dependent Care FSA Account

You qualify to use this account if:

- you are a single parent and work full time;
- you have a working Spouse;
- your Spouse is a full-time student for at least five (5) months during the year, and while you are working; or
- your Spouse or other adult dependent is disabled and unable to provide for their own care.

Eligible Dependent Care Expenses

Expenses may be reimbursed for services provided:

- inside or outside your home by anyone other than the following individuals:
  - your Spouse;
  - someone who is your dependent for income tax purposes;
  - the child's parent (if the parent is not your Spouse); or
  - one of your children under the age of 19.
- in a dependent care center or a child-care center (if the center cares for more than six (6) people, it must comply with all applicable state or local regulations); or
- by a housekeeper whose services are primarily for providing care for an eligible dependent; or
- by before or after school programs;
- by an elder care provider; or
- by an au pair.

Ineligible Dependent Care Expenses

In general, any expenses that cannot be claimed as dependent care expenses for income tax purposes are not reimbursable through the Dependent Care FSA. Ineligible expenses include, but are not limited to, the following:

- overnight camp
- activity fees (*e.g.* dance lessons)
- educational, learning or study skills services
- field trips
- summer school
- household services (housekeeper, maid, cook, etc.)
- language classes

- kindergarten tuition
- nursing home

To make sure your situation and the type of care being provided meets IRS requirements; please refer to the EBPA web site at www.ebpabenefits.com.

Maximum Tax-Free Reimbursement for Dependent Care

Generally, amounts reimbursed from your Dependent care FSA are tax-free to you. However, federal law states that the amount excluded from your gross income cannot exceed, in any calendar year (under *all* dependent care plans in which you or your Spouse may participate) the lesser of:

- $5,000 ($2,500 if you are married and filing separate federal income tax returns);
- your annual income; or
- your Spouse's annual income.

If your Spouse is (1) a full-time student for at least 5 months during the year or (2) physically and/or mentally disabled, there is a special rule to determine their annual income. To calculate the income, determine your Spouse's actual taxable income (if any) earned *each month* that they are a full-time student or disabled. Then, for each month, compare this amount to either $250 (if you claim expenses for one dependent) or $500 (if you claim expenses for two or more dependents). The amount you use to determine your Spouse's annual income is the greater of the actual earned income or 12 times the assumed monthly income amounts of either $250 or $500.

If you are married and filing separate federal income tax returns, the maximum limit described above will not apply to you if you are (1) legally separated or (2) separated for more than 6 months and pay for more than half of the household expenses.

By making an election under the Dependent Care FSA, you are representing to the University that your contributions to the Dependent Care FSA are not expected to exceed these limits.

To qualify for tax-free treatment, you are required to list on your federal income tax return the names and taxpayer identification numbers of any person who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. The identification number of a care provider who is an individual and not a care center is that individual's Social Security number. You should make your care provider aware of this reporting requirement.

Federal Dependent Care Tax Credit

Dependent care expenses for which you are reimbursed from your Dependent Care FSA will not qualify for the federal tax credit available with respect to dependent care expenses. Under the Code, you are entitled to a dollar for dollar credit against your income tax liability in an amount equal to a specified percentage of your qualifying dependent care expenses. For purposes of the credit, there are limitations on the dollar amount of qualifying dependent care expenses that can be taken into account. These limitations are reduced dollar for dollar by dependent care expenses reimbursed under the Dependent Care FSA. In addition, these expenses cannot be taken into account to the extent they exceed the lesser of your or your Spouse's earned income.

Therefore, you should determine whether it is more advantageous for you not to establish a Dependent

Care FSA in order to avail yourself of the federal tax credit. In making this determination, it is important to consider that the amount of compensation you elect to reduce is not subject to federal income tax, state income tax, and is not subject to Social Security withholding tax (FICA). If you are not certain as to what extent, if any, it is to your advantage to participate in the Dependent Care FSA, you should consult your personal tax advisor.

How to File for Reimbursement from the Flexible Spending Accounts

The Tufts University Flexible Spending Accounts are administered by EBPA.

Some expenses are easier to pay for and then get reimbursed from your Health Care or Dependent Care FSA. Using the Reimbursement Request Form, you can be reimbursed by submitting a claim form to EBPA with accompanying receipts or bills:

- By Fax: 1-603-773-4415
- By mail to: EBPA - P.O. Box 1140, Exeter, NH 03833-1140
- By email: fsa@ebpabenefits.com

Reimbursement Request Forms are available at www.ebpabenefits.com. Alternatively, you can complete an on-line reimbursement request via www.ebpabenefits.com.

Use this feature to submit for reimbursements on-line. Once you enter your receipt information, provide an electronic copy of your itemized bill or explanation of benefits that contains: date of service, description of service, provider name, cost and name of person receiving care, confirm payment information (reimbursement by direct deposit or check), your claim will be processed.

EBPA Benefits Debit Card (For Health Care Flexible Spending Account)

For out-of-pocket health care expenses that are to be paid at the point of service (co-pays, prescription drugs, vision or dental care, etc.), you can use your EBPA Benefit debit card. When you swipe your debit card, the provider is paid automatically from your account and you do not have to pay out of pocket and request reimbursement. Please remember to save your receipts in case of audit or for an EBPA request for substantiation.

FSA Reimbursement and Forfeiture

Expenses under the Health Care FSA will be reimbursed in full up to the amount of your yearly election, less any claim amounts previously reimbursed. Expenses under the Dependent Care FSA will be reimbursed up to your current account balance. Expenses incurred before you elect an FSA or after you terminate your FSA election will not be reimbursed. Expenses are incurred when services are provided, not when you pay for the services (with the exception of orthodontia expenses for which you may submit a single advance payment if the advance payment is necessary to receive such services). All expenses incurred during the time you are eligible must be submitted by April 30 of the following year to be reimbursed under the FSAs. **If expenses are not submitted in accordance with these rules and you have a balance in the Dependent Care FSA at year end (after the April 30 submission date has passed**), then you will forfeit the balance of your Dependent Care FSA account. If expenses are not submitted in accordance with these rules and you have a balance in the Health Care FSA at year-end (after the April 30 submission date has passed), then you may carry over up to $500 of your Health Care FSA balance into the next plan year, provided you are still employed in the next plan year, and elect the minimum

Health Care FSA. Any balance amounts in excess of $500 will be forfeited.

Note: Upon termination of employment, you will be eligible to receive reimbursement from the Health Care FSA for the full amount of your yearly election (less any claims already reimbursed) for all health expenses incurred up to the date that your participation in the Health Care FSA ends. However, the amount of reimbursements that you will be eligible to receive from the Dependent Care FSA may not exceed the amount that has been contributed to your Dependent Care FSA as of your termination date and you may be reimbursed only for dependent care expenses incurred as of your termination date. You will have only 120 days from your termination date to submit expenses incurred in the calendar year prior to your termination.

LIFE INSURANCE

Life insurance coverage offered under the Group Term Life Insurance Plan provides your designated beneficiary with benefits in the event of your death. You must designate your beneficiary or beneficiaries in writing, by completing a beneficiary designation on your enrollment form or making a designation online via Employee Self Service at https://access.tufts.edu/get-work-done/my-information/eserve. If you do not designate a beneficiary or beneficiaries, the benefit plan vendor will determine who receives your life insurance benefits in the event of your death in accordance with the terms of the Group Term Life Insurance Plan. Your eligible dependents may also be covered by life insurance through the University Plan. If your covered dependent dies, you will receive the life insurance benefits. Life insurance benefits are generally payable in a lump sum based upon the coverage option that you and/or your dependents choose. Please refer to Appendix A at the back of this booklet for information regarding the benefit plan vendor for the University's life insurance coverage.

Coverage Options for Employees:

The University's Group Term Life Insurance Plan offers the following two coverage options for employees:

Basic Life Insurance:

The amount of coverage is equal to one (1) times your basic annual earnings, rounded to the next highest $1,000, with a maximum of $1,000,000. This coverage is provided at no cost to you by the University.

Supplemental Life Insurance:

You may purchase up to five (5) times your annual base salary (maximum of $2,000,000).

Amounts in excess of three (3) times your annual base salary (maximum of $750,000) require submission and acceptance of an Evidence of Insurability form.

Your life insurance benefit will be paid in a lump sum to your beneficiary upon your death, or you may elect to receive an accelerated death benefit, meaning that the death benefit is paid to you during your lifetime if you have been diagnosed with a terminal illness with a life expectancy of 24 months or fewer. Your Basic Life Insurance and Supplemental Life Insurance coverage amounts will be reduced to the percentage indicated below as of the first day of the month following the date you attain the specified age listed below:

	Age 70	**Age 75**	**Age 80**	**Age 85**
Benefit <u>After</u> Reduction	65%	45%	30%	25%

Reduced amounts of life insurance will be rounded to the next higher multiple of $1,000, if not already such a multiple. For this benefit for employees age 70 and older, the coverage amount will be rounded prior to applying the benefit reduction percentage.

Please refer to the booklets and other descriptive materials you receive from the University and the benefit plan vendor for more information.

<u>Coverage Options for Dependents:</u>

Spouse/Domestic Partner (DP):

Note: Your Spouse/DP's insurance coverage amount ($25,000 or $50,000) cannot exceed 100% of your combined employee basic and supplemental life insurance coverage amounts. The University's Group Term Life Insurance Plan offers the following two coverage options for your Spouse/DP:

Option	Coverage
Option 1	$25,000
Option 2	$50,000

Child(ren):

You may elect life insurance coverage for each of your dependent children in the amount of $10,000.

Your dependent's life insurance benefit will be paid in a lump sum upon the dependent's death, or you may elect to receive an accelerated death benefit, meaning that the death benefit is paid during your dependent's lifetime if they are diagnosed with a terminal illness with a life expectancy of 24 months or fewer.

<u>Paying for Coverage</u>

The University pays the full cost of Basic Life Insurance coverage for you. If you elect Supplemental Life Insurance coverage for yourself or coverage for your dependents, you are required to pay the full cost of the coverage you select. The University determines the amount that you are required to pay each year.

Portability and Conversion

You may be able to elect to take your life insurance coverage with you if you terminate employment and meet certain other requirements. If you do not elect to take your life insurance coverage with you in accordance with the life insurance portability provisions, you may be able to convert your coverage to an individual whole life policy. For information on portability and conversion, please refer to the booklets and other descriptive materials provided to you by the University and the plan benefit vendor.

Accidental Death and Dismemberment Insurance (AD&D)

Your life insurance coverage also includes voluntary Accidental Death and Dismemberment insurance benefits if you elect them. You may elect a guaranteed issue benefit amount of up to 5 times your annual base salary, rounded to the next higher $1,000 if not an even multiple, subject to a maximum of $1,000,000.

Your Accidental Death and Dismemberment Insurance will be reduced to the percentage indicated below as of the first day of the month following the date you attain the specified age listed below:

	Age 70	Age 75	Age 80	Age 85
Benefit After Reduction	65%	45%	30%	25%

Reduced amounts of Accidental Death and Dismemberment insurance will be rounded to the next higher multiple of $1,000, if not already such a multiple. For this benefit for employees age 70 and older, the coverage amount will be rounded prior to applying the benefit reduction percentage.

Refer to the booklets and other descriptive materials you receive from the University and the benefit plan vendor for more information.

LONG TERM DISABILITY

Long term disability insurance coverage under the Group Long Term Disability Plan provides you with disability benefits in the form of a monthly benefit when you are unable to work for an extended period of time because you are "Disabled" due to an injury or sickness. You must be Disabled for 180 consecutive days before long term disability benefits are payable. Dependents are not eligible for long term disability insurance coverage. Coverage is guaranteed issue if elected at initial enrollment. Any other time, enrolling or increasing your LTD benefit requires you to apply for coverage and receive approval from the insurance company.

You will be considered to be "Disabled" if due to an injury or sickness you require the regular care and attendance of a doctor and:

- are unable to perform the material and substantial duties of your regular occupation or have a 20% or more loss in your monthly earnings;
- after the first 24 months of benefit payments, you are unable to perform each of the material

duties of any gainful work which you are reasonably qualified to do based on your training, education, experience and past earnings; OR

- while unable to perform all of the material duties of your regular job on a full-time basis, are:
- performing at least one of the material duties of your regular occupation or any other gainful work on a part-time or full-time basis; and

- earning currently at least 20% less per month than your indexed basic monthly earnings due to the same injury or sickness.

Coverage Options

The University's Group Long Term Disability Plan offers the following two coverage options:

- Option I (40% Coverage):

The monthly benefit is the lesser of:

- $12,000 minus any other income benefits you receive from other sources; or

- 40% of your basic monthly earnings minus any other income benefits you receive from other sources

- Option II (60% Coverage):

The monthly benefit is the lesser of:

- $12,000 minus any other income benefits you receive from other sources; or

- 60% of your basic monthly earnings minus any other income benefits you receive from other sources.

Effective January 1, 2017, new hires and newly eligible employees will be automatically enrolled in the 60% option for the long term disability benefit. You may change the election to the 40% option of or waive coverage during your initial enrollment period or in any subsequent annual Open Enrollment period.

Regardless of which option you choose, the maximum monthly benefit that is available under the plan is $12,000 and the minimum monthly benefit is 10% of the monthly benefit (before other income benefits are deducted) or $100, whichever is greater.

Pre-existing Condition Limitation:

A pre-existing condition limitation will apply during your first year on the Group Long Term Disability Plan or when you increase your coverage. You have a pre-existing condition for purposes of the plan if you received treatment, consultation, care or services; took prescription medication or had medications prescribed or had symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment in the **three (3) months** before your insurance or any increase in the

amount of insurance takes effect. You cannot receive benefits if you become disabled from a disability that results from such pre-existing condition for a period of **twelve (12) consecutive months** from the date your insurance or your increased amount takes effect. After the twelve (12) months ends, a disability related to pre-existing condition(s) will be covered.

Paying for Coverage

You are required to pay the full cost of the long term disability coverage you select. The contribution you are required to pay is determined by the University each year.

Maximum Benefit Duration

The Maximum Benefit Duration **is the greater of**:

1. the Benefit Duration limit as shown in the table below; or
2. your normal retirement age as defined by the Social Security Amendments of 1983 (Social Security Retirement Age).

AGE WHEN TOTAL DISABILITY BEGINS	BENEFIT DURATION
LESS THAN 60	TO AGE 65
60	60 MONTHS
61	48 MONTHS
62	42 MONTHS
63	36 MONTHS
64	30 MONTHS
65	24 MONTHS
66	21 MONTHS
67	18 MONTHS
68	15 MONTHS
69 AND OVER	12 MONTHS

Critical Illness

You will be entitled to a critical illness benefit if the insurance company determines that you have a critical illness which is the same sickness or injury that caused your disability, and when you are under the regular care of a doctor. If approved, the critical illness benefit is equal to 5% of your monthly earning (cannot exceed more than an additional $1,000). Your monthly critical illness payment, together with your monthly LTD payment, cannot exceed your monthly earnings.

Rehabilitation Incentive

If you participate in a rehabilitation program approved by the benefit plan vendor while you are disabled, your monthly benefit percentage will be increased by 5%.

Child Care Expense Benefit

You may be eligible for a child care benefit of up to $500 per month for each eligible child during the first 6 months of your monthly benefit payments while you are participating in a rehabilitation plan.

Cost of Living Adjustment

A 3% cost of living adjustment will be calculated on July 1 each year if you are disabled and not working on that date and have been disabled for all of the 12 months before that date.

Important Note Regarding Health Insurance

Qualified long term disability claimants may retain Health Plan coverage through the University's active employee plan until reaching normal Social Security Retirement Age, unless they cease being disabled. The University pays the full cost of this coverage if the employee has health coverage at the time LTD is approved. Please contact Tufts Support Services (TSS) regarding other benefits while on long term disability.

Coverage Conversion

Enhanced benefits include a conversion provision that allows you to convert your coverage to an individual policy if you leave the University for other employment.

If you are interested in conversion or portability, please call Prudential at 800-778-3827 and refer to policy number 46943.

LONG TERM CARE

The Group Long Term Care Plan is available only to employees who were enrolled in the Group Long Term Care Plan as of June 30, 2013. This Plan is not open for new enrollees after June 30, 2013. If you are enrolled in the Group Long Term Care Plan, then the Plan provides you and your covered dependents with long term care insurance benefits as outlined in the schedule below if a licensed health care practitioner has certified that you are qualified for benefits. You will be qualified for benefits if, in the preceding 12 months, you were unable to perform for a period of 90 days, at least two of the following activities of daily living without substantial supervision due to the same or a related condition (including a severe cognitive impairment): bathing, continence, dressing, eating, toileting, and transferring. Long term care benefits will be paid pursuant to a plan of care provided by a licensed healthcare practitioner. You must have received long term care for 90 consecutive days (the "Elimination Period") before long term care benefits are payable.

The University's Group Long Term Care Plan is fully insured through group insurance policies provided by Prudential. The terms of the Prudential long term care insurance plans are described separately below. If you are enrolled in the plan and have questions, you can contact Prudential, at the number listed below.

Long Term Care through Prudential

Paying for Coverage

You are required to pay the full costs of the long term care coverage you select for yourself and your dependents. The contribution you are required to pay is determined by the rate for your age upon initial enrollment, plus the age you are when you elect to accept any optional benefit increase.

Waiver of Premium

Premiums for coverage will be waived on a monthly basis beginning with the first premium due after you have completed the Elimination Period and premiums will continue to be waived until no benefits have been paid for 6 months.

Continuation of Coverage

Long term care coverage is provided to you on a discounted basis through the buying power of the University. The coverage belongs to you, and will remain with you, if you choose, after you terminate employment.

Temporary Bed Holding Benefit

The plan pays a temporary bed holding benefit which allows you to hold a bed in a nursing home if you are absent from the nursing home due to a hospital stay or other event.

Caregiver Training Benefit

The plan pays a caregiver training benefit to train an informal caregiver so that you do not have to stay in a nursing home or receive care at home from a paid provider.

Emergency Alert System Benefit

The plan pays an emergency alert system benefit for the rental or lease of an emergency alert system for your residence so that medical attention may be summoned in the event of medical emergency.

Hospice Care Benefit

The plan pays a hospice care facility benefit for patients who are expected to live less than six months.

International Coverage

Prudential pays one year of nursing home or assisted living benefits and then the alternative care benefit will apply. See Prudential Plan document for details.

Refund of Premium at Death

A portion of the premiums paid less any benefits paid or payable may be refunded upon the insured's death.

Please refer to the booklets or other descriptive materials that have been provided to you by the University or the benefit plan vendor for specific details and additional information regarding long term care benefits.

Contact Information

Contact Prudential at 800.732.0416 from 8 a.m. to 8 p.m. ET, Monday through Friday with any questions about existing coverage.

LEAVING THE UNIVERSITY – REDUCTION IN FORCE POLICY FOR STAFF

A reduction in force is the elimination of a staff position such as a change in a University program, department reorganization, budgetary restriction, or the expiration of a grant or contract. Reduction in force proposals are reviewed by the appropriate Dean or Director as well as by the Vice President for Human Resources, to ensure that the reduction is implemented according to University Policy. This Policy does not apply to temporary lay-offs or to faculty. This Policy covers regular staff employees who work an average of 17.5 hours per week or more. Special provisions apply to employees working under externally funded grants or contracts and to employees who have worked for the University for ten (10) years or more.

These provisions are outlined below:

Employees under Grants or Contracts

Persons employed under grants or contracts at the time a reduction in force is implemented are not eligible for severance pay but are covered by the remainder of this Policy.

Notice of Reduction in Force

An employee whose position is being eliminated will ordinarily receive at least six (6) weeks written notice of the action. Employees receiving such notices are encouraged to contact a Human Resources Business Partner, who can further explain the Policy and assist the employee in applying for other positions.

Consideration for Other Employment

An employee whose position has been eliminated will receive primary consideration for employment in other positions at the University for which the employee is qualified and which are at the same or similar level.

Primary consideration means that when an individual covered under this Policy applies for an open position, they will be granted an interview by a Human Resources Representative. If the qualifications of the individual are deemed to be an appropriate match with the position requirements, a referral to the hiring supervisor may be made.

The ultimate hiring decision is left to the hiring supervisor. This consideration remains in effect for one (1) full year from the separation date of the employee. If a reduction is due to the University's decision to purchase the services previously performed by University employees from an outside contractor, the new supplier will be encouraged to employ individuals affected. Rehired employees are eligible for reduction in force benefits, including six weeks' notice and severance pay as of the date of rehire. Reduction in force benefits are based on full or partial years of service beginning with the date of rehire

in the current position.

Severance Pay (excluding positions that are grant-funded)

Persons not employed under grants or contracts are eligible for severance pay. If another suitable position is not found prior to expiration of the notice period, eligible employees will receive one (1) week of salary for each full or partial year of service, with a minimum of two (2) and a maximum of sixteen (16) weeks. Unused vacation time accrued up to the day of separation will also be paid.

An employee who has received notice of a reduction in force may leave the University prior to the expiration of the notice period. For the purposes of salary and record keeping, the date of departure will then become the termination date. If an employee selected for reduction is offered a comparable job within the University or with a subcontractor or lessee of the University, they will not receive severance pay or other benefits under this Policy. A comparable job is defined as one at or near the same salary, benefits, and level of responsibility.

Review Procedure for Long-term Service Employees

The University has established a policy that long-term service employees may request a review at the highest level of the administration whenever a position held by a long-term service employee is eliminated due to a reduction in the work force, unless such a reduction results from the expiration of a grant or contract. For purposes of this procedure, a long-term service employee is defined as a non-exempt employee who has completed ten (10) or more years of continuous service at Tufts. Prior to requesting a formal review under the procedures outlined below, employees should discuss with their supervisor and the Vice President for Human Resources whether comparable jobs are available within the University. If the outcome of these discussions does not meet the employee's satisfaction, they may pursue the two-step review procedure described in the Tufts University Employee Handbook. Please refer to the Handbook.

Severance Policy for Certain Part-time Lecturers

The collective bargaining agreement between the University and the Service Employees International Union Local 509, CTW, CLC ("Agreement") provides specific severance benefits for covered part-time lecturers in lieu of the general severance benefits provided under the Reduction in Force Policy. The specific terms are set forth in Article 11, Section 15 of the Agreement, which is incorporated by reference and treated as part of the Policy. Covered employees may obtain a copy of the Agreement at any reasonable time at the office of the Plan Administrator.

ERISA Welfare Plan

Benefits payable under the Policy are welfare benefits under ERISA. The Plan Administrator will notify you if you become entitled to benefits under the Reduction in Force Policy. If you are not notified and you believe that you are entitled to benefits or if you believe the amount of your benefits is incorrect, then you may submit a claim for benefits under the Claims and Appeal Procedures described below. If you are covered under the Agreement noted above, then you may also take action sanctioned by the Agreement.

BUSINESS TRAVEL ACCIDENT INSURANCE

Tufts University's Business Travel Accident Insurance Plan is administered by Chubb for Federal Insurance Company.

Eligibility

The Business Travel Accident Insurance (BTA) Plan provides benefits for employees, active full-time corporate officers, enrolled students, alumni, and invited guests (Primary Insured Persons) while traveling on University business or University sponsored/approved travel (Business Travel). Business Travel means travel by the Primary Insured Person who is (i) away from the Primary Insured Person's regular place of employment at the direction of the University and (ii) on University business, for a period of 180 days or fewer. Business Travel does not include commutation, except for extraordinary commutation resulting from a discontinuance of public transportation due to a strike, major breakdown, or catastrophic cause.

The BTA Plan also extends limited coverage and benefits for spouses/domestic partners (DPs), and dependent children of employees, corporate officers, and alumni accompanying them.

Benefits

The BTA Plan provides life insurance, accidental death and dismemberment, medical expense, partial disability, permanent total disability, coma, paralysis, and other additional benefits. It provides War Risk and Political Evacuation benefits (including repatriation), and expenses incurred/benefits due to hijacking, skyjacking, carjacking, felonious assault, coma, bomb scare, and relocation. Finally, the University's BTA Plan includes worldwide travel assistance that provides emergency medical and emergency travel services.

Please contact Tufts Support Services at 617-627-7000 for additional information about benefits and exclusions under the BTA Plan.

Paying for Coverage

Tufts University pays the full cost of this coverage.

TUFTS UNIVERSITY-FUNDED RETIREMENT PLAN – 401(a)

The Tufts University-Funded Retirement Plan can help you build savings for your retirement years. The University Funded Retirement Plan is a savings and investment plan that qualifies for special tax treatment. Participation in the University-Funded Retirement Plan should be an important component of your retirement, since any money you have accumulated in the University-Funded Retirement Plan at the time you retire will be available to supplement your Social Security benefits and personal savings. Your Normal Retirement Date under the Plan is your 60th birthday.

Contributions

University Contributions

For each plan year (January 1 – December 31), in which you are an Eligible Employee who is regularly scheduled to work at least 17.5 hours a week, or a faculty member with at least a half-time, two-semester appointment, the University will make a contribution to the University-Funded Retirement Plan on your behalf in the amount shown below. For any other Eligible Employee, the University will make a contribution to the University-Funded Retirement Plan in the amount shown below for each plan year in which the employee is credited with at least 1,000 hours of service (generally each hour for which you are paid for work, including paid absences). University contributions are made at least monthly, except that if you are an Eligible Employee described in the second sentence (but not the first sentence) of this paragraph, the contribution will be made for you as soon as reasonably practicable after the last day of the plan year to which it relates.

These contributions will be based on your age, your *Covered Salary* and the *Social Security Wage Base* as follows:

Your Age Before First Day of Month of Contribution	Contribution as a % of Covered Salary Up to Social Security Wage Base	Contribution as a % of Covered Salary Over Social Security Wage Base
21 through 39	5%	10%
40 or over	10%	15%

Your *Covered Salary* is your total base salary earned while a Participant before any reduction under any of the following: Self-Funded Retirement Plan, cafeteria and flexible spending account plans of the University described in Code Section 125, or under Code Section 132(f)(4), 401(k) or 457. Covered salary does not include imputed income or stipends, awards, prizes, honoraria, overtime, bonuses, lump sum payments for accrued unused vacation made after your termination of employment from the University, or any other payments that are supplemental to base salary (other than summer supplement pay that is based on a faculty member's current rate of pay). Federal tax law limits the **Covered Salary** that may be taken into account under the University-Funded Retirement Plan. This **Covered Salary** limit for 2018 is $275,000. Accordingly, if your total base salary for 2018 exceeds the **Covered Salary** limit, you will not be entitled to a University contribution with respect to that part of your salary that exceeds the limit. This *Covered Salary* limit will be adjusted from time to time by law and may increase for 2019. For purposes of the University's monthly contributions, your Covered Salary is annualized over the calendar year.

The Social Security Wage Base is defined by law and adjusted each calendar year. For 2018, the Social Security Wage Base is $127,200 and may increase for 2019.

If you became an employee of the University before January 1, 1986, and were under the age of 40, the table above did not apply until January 1, 1986. Instead, the University contributed 8% of your Covered Salary up to the Social Security Wage Base and 13.5% over the Social Security Wage Base until you reached age 40. As of the first of the month following your 40th birthday, the University's contributions increased to the levels shown in the table above.

If you continue working after your Normal Retirement Date (your 60th birthday), the University will continue to make contributions on your behalf until the date you actually retire.

Contributions for Disabled Participants: If you are a Participant in the University-Funded Retirement Plan, the University will make contributions to the University-Funded Retirement Plan on your behalf while you are receiving benefits from the Group Long Term Disability Plan. The amount of such contributions will be determined in accordance with the general provisions of the University-Funded Retirement Plan as if your Covered Salary during the period of your disability were the same as your Covered Salary immediately before the period your disability began. The contributions will continue until the earliest of the following events: the termination of your disability, your death, the date you start to receive benefits under the University-Funded Retirement Plan, and the date on which you cease to receive benefits under the Group Long Term Disability Plan. If you were disabled before November 1, 1985, please contact Tufts Support Services (TSS) for details about the contributions made on your behalf.

Limitations: Because of restrictions imposed by federal tax law, the University-Funded Retirement Plan contains provisions which may, in certain circumstances, further limit the amount of contributions which the University might otherwise be able to make for any given tax year.

Employee Contributions

Employee contributions are not permitted under the University-Funded Retirement Plan.

Rollover Contributions

The University-Funded Retirement Plan does not accept "rollover" contributions from a previous employer's eligible retirement plan or an individual retirement account ("IRA"). However, if you are a Participant in the Self-Funded Retirement Plan, you may be eligible to make rollover contributions to that Plan. See the section entitled Self-Funded Retirement Plan - *403(b)* for further information.

Investment of University-Funded Retirement Plan Account

A University-Funded Retirement Plan account will be established in your name under the University-Funded Retirement Plan to hold your share of contributions and investment gains or losses. Although the University makes contributions on your behalf, you are responsible for investing those contributions.

Your Investment Options Under the University-Funded Retirement Plan

You may direct the investment of the funds in your University-Funded Retirement Plan account in the investment options (annuity contracts and mutual funds) offered under the University-Funded Retirement Plan by the Plan's investment vendors: Fidelity Investments ("Fidelity") and Teachers Insurance and Annuity Association ("TIAA").

Fidelity Mutual Funds: You may invest your University-Funded Retirement Plan account in shares of mutual funds offered by Fidelity or offered through the Fidelity platform. If you leave the University and you are vested in the University-Funded Retirement Plan, your account balance will remain in the University-Funded Retirement Plan until you request a distribution of your vested University-Funded Retirement Plan account or until you are required by law to receive a

distribution (generally April 1 following the later of calendar year in which you attain age 70½ or the calendar year in which you retire from the University). In addition, you may direct the investment of your account through a participant-directed brokerage account offered through the Fidelity platform. The investment options available through a participant-directed brokerage account are limited to Fidelity and non-Fidelity mutual funds.

TIAA: You may invest your University-Funded Retirement Plan contributions in Annuity Contracts offered by TIAA. As of April 28, 2011, mutual funds offered through TIAA are no longer offered as an investment option for future contributions. If you leave the University and you are vested in the University-Funded Retirement Plan, your account balance will remain in the University-Funded Plan until you request a distribution of your vested University-Funded Retirement Plan account or until you are required by law to receive a distribution (generally April 1 following the later of the calendar year in which you attain age 70½ or the calendar year in which you retire from the University).

Descriptions of all of the investment options available under the University-Funded Retirement Plan through the investment vendors are included in separate booklets that are available online at http://fidelity.com/atwork and http://tiaa.org/tuftsuniversity. You can also request copies of these booklets by contacting the investment vendor directly. Please note that the Plan fiduciaries may add or eliminate investment options at any time at their discretion.

How Your University-Funded Retirement Plan Account is Invested

Future Contributions

When you first become a Participant in the University-Funded Retirement Plan, your account will be invested in an age-appropriate Target Date Fund, which is the designated "default" investment for the University-Funded Retirement Plan. You may allocate all or a portion of your account, as well as future contributions to your account, among the two investment vendors: Fidelity and TIAA. If you want to choose Fidelity as you vendor for future contributions, no action is required since they are the default vendor.

To change your vendor selection for future contributions to TIAA or split your contributions between both vendors, you must first contact TIAA to allocate up to 100% of your future contributions between the TIAA Traditional and/or CREF Stock Fund options. Contact TIAA at 800-842-2776 or log into http://tiaa.org/tuftsuniversity. Secondly, log into https://access.tufts.edu/get-work-done/my-information/eserve to change your vendor selection to TIAA or designate the percentage of your contribution between Fidelity and TIAA. Until you complete both steps, 100% of your future University-Funded Retirement Plan contributions will be directed to the Plan default, the age-appropriate Target Date fund at Fidelity. Once you change your vendor election online, the change will be effective with the next available payroll.

If you do not have internet access, you may change your investment election as to future contributions by submitting a completed University-Funded Retirement Plan Authorization for Investment Vendor Election form to Tufts Support Services (TSS) after you contact TIAA to make your investment elections as noted above. You may contact Tufts Support Services (TSS) to obtain this form.

If you select Fidelity as your vendor of choice, your contributions will be invested in the Plan default, an age-appropriate Target Date fund, unless you actively choose investment allocations by contacting Fidelity at 800- 343-0860 or by logging into http://fidelity.com/atwork.

Target Date Funds provide a mix of different investments – in large and small companies, both domestic and foreign, and in both equity and fixed-income instruments – typically by investing in other mutual funds offered by the same vendor. The funds are professionally managed to target specific retirement dates, in 5-year intervals, which mean that the overall asset allocation becomes more conservative as a particular fund's target retirement date approaches. Accordingly, the risk and return characteristics of the funds vary with their target retirement dates.

Current Balances

You may change the way your current balances are invested by contacting your investment vendor directly. Transfers of past contributions credited to existing account balances are permitted to the extent allowed by law and by the terms of the investment vendor's contracts. If you wish to make a transfer between vendors, please contact the vendor to whom you wish to transfer to and they can assist you with completing the transaction.

Please note that although you may transfer your University-Funded Retirement Plan assets among the various investment options offered under the University-Funded Retirement Plan, you may not transfer your University-Funded Retirement Plan assets to the Self-Funded Retirement Plan, or your Self-Funded Retirement Plan assets to the University-Funded Retirement Plan.

Investment Responsibility

The University-Funded Retirement Plan is intended to constitute a plan described in Section 404(c) of the Employee Retirement Income Security Act, and Title 29 of the Code of Federal Regulations, Section 2550.404c-1. This means the University-Funded Retirement Plan lets you choose from a broad range of investments, and you can (and have the responsibility to) decide for yourself how to invest the assets in your University-Funded Retirement Plan account. The investment options offered by the University-Funded Retirement Plan are broadly diversified, as to risk and return, in order to allow you to diversify your retirement savings portfolio in a manner consistent with your individual needs.

Section 404(c) provides that the fiduciaries of a plan may be relieved of liability for any losses that are the direct and necessary result of investment instructions given by a participant or beneficiary. Thus, the University, the Plan Administrator, and others responsible for the operation of the University-Funded Retirement Plan (the University-Funded Retirement Plan's "fiduciaries") will not be liable for any losses that are the result of investment instructions given by you, your beneficiaries, or an alternate payee. It is extremely important that you learn about the various investment options before deciding how to allocate your contributions. Before making your election, you should:

- evaluate all of your investment options carefully;
- develop a long-range personal retirement savings goal;
- decide how much risk you are willing to take to achieve your goal; and
- be aware that investments offering a greater investment return may be subject to greater risk.

To balance your risk and return effectively, you should diversify your investments. Diversifying your investments means spreading your savings among different types of investments and asset classes, such as stocks, bonds, and short-term investments such as cash. Dividing your money among several types or classes of investments with different degrees of risk and different risk characteristics means that your retirement savings will not depend on the performance of one single type of investment or asset class. No one at the University is authorized to give investment advice with respect to the University-Funded Retirement Plan. If you have questions about investing, you should consult a professional financial advisor who can help you make decisions about your investments. However, the investment vendors can help you collect information that might assist you in making your decision.

In this regard, you are entitled to the following additional information upon request to Fidelity or TIAA, as applicable, at the addresses and telephone numbers listed on page 87.

1. Copies of any prospectuses (or, alternatively, any SEC-approved short-form or summary prospectuses), financial statements and reports and other similar materials relating to the investment funds, to the extent such information is provided to the University-Funded Retirement Plan;

2. A list of assets comprising the portfolio of each investment fund that constitute Plan assets, the value of each such asset (or the proportion of the investment that it comprises); and

3. A statement of the value of a share or unit of each investment fund, as well as the valuation date.

The investment choices in the University-Funded Retirement Plan include the following:

- **Vanguard Target Date Funds**
  - This option includes professionally managed, diversified portfolios with targeted specific retirement dates, in 5-year intervals, which mean that the overall asset allocation becomes more conservative as a particular fund's target retirement date approaches. Accordingly, the risk and return characteristics of the funds vary with their target retirement dates.
- **Core Funds**
  - Investment options include a diversified selection of funds offered by Fidelity, TIAA, and a variety of other mutual fund companies.

- **Fidelity Brokerage link accounts**
  - Investment options include any of the Fidelity mutual funds not available in the Core Funds and non-Fidelity mutual funds.

Vesting

Becoming Vested in Your University-Funded Retirement Plan Account

If you are vested, you have a right to the value of your University-Funded Retirement Plan account (*e.g.*, the University's contributions adjusted for investment gains and losses) when you leave the University or in certain other circumstances discussed below.

You become vested in your University-Funded Retirement Plan account based on your years of vesting service in accordance with the following schedule:

Years of Vesting Service*	Your Vesting Percentage Relating to the University Contribution
Less than 3	0%
3 or more	100%

*See the section entitled *Service Computation Rules – Vesting* below for information on how you are credited with years of vesting service.

You will become 100% vested in your University-Funded Retirement Plan account, regardless of your years of vesting service, if:

- you reach age 60 while you are an active participant (or you turned age 50 while a participant before May 1, 1997);
- you become totally and permanently disabled and are entitled to receive benefits under the Tufts University Group Long Term Disability Plan; or
- you were an employee of the University on December 31, 1988 who participated or was eligible to participate in the Tufts University Retirement Plan then in effect.

Service Computation Rules – Vesting

For purposes of determining when you have completed 3 years of vesting service under the University-Funded Retirement Plan, service is measured by the *elapsed time* method. In general, under this method of calculating your vesting service, your period of service starts with the day you first began working at the University and ends when your University employment ends. For example, if you begin work on February 1, 2015, you will complete your 3-year period of service on January 31, 2018, assuming you do not leave the University employment before that date.

If you were employed by the Museum of Fine Arts, School of the Museum of Fine Arts and earning vesting credits and immediately transferred to employment with Tufts between July 1, 2016 and September 1, 2016, your years of vesting service under the University-Funded Retirement Plan will include your years of vesting service credited under the Museum of Fine Arts Defined Contribution Retirement Plan ("MFA Plan"). For example, if you were credited with two years of vesting service under the MFA Plan as of June 30, 2016, and became an employee of the University on July 1, 2016, you were credited with 3 years of vesting service under the University-Funded Retirement Plan on June 30, 2017, as long as you remained employed by Tufts University on that date.

A special rule applies if you are absent from work for a reason other than termination of employment. For example, if you are absent from work due to an authorized leave of absence, disability, sickness, or layoff, but are still employed by the University, your period of service will include the first 12 months of your absence. If you return to work within that 12-month period, your period of service begins on your

original employment date, continues through your absence and your return, and ends on the date your employment terminates.

Please note: A special rule also applies if you are absent from work due to military service within the meaning of USERRA. If you are reemployed by Tufts University following a USERRA military leave, then your period of military leave will not be treated as a break-in-service and your military leave will be counted as active service for vesting purposes.

In addition, the elapsed time method includes *service spanning* rules that give you credit for short periods (fewer than 12 months) between a termination and resumption of your University employment. For example, if you terminated your University employment on May 31, 2017, and returned to your job on May 1, 2018, your period of service for vesting purposes would include the entire period of your absence (from May 31, 2017 through May 1, 2018) even though you were not employed by the University during that time. The only exception to this rule applies when your termination of employment occurs during the first 12 months of an absence from work for a reason other than termination of employment (*e.g.*, during a leave of absence). In that case, the service spanning rules will apply only if you resume your University employment within 12 months after your absence began, rather than 12 months after termination.

Effects of a Break-In-Service

If a period of service ends under the rules above *after* you have become vested under the University-Funded Retirement Plan, your service before the break-in-service will be reinstated upon your resumption of employment at the University. If a period of service ends under the rules above *before* you have become vested under the University-Funded Retirement Plan, your service before the break-in-service will be reinstated upon your resumption of employment only if you resume employment less than *5* years after your period of service ended. If, before you become vested, your period of service ends after 12 months of absence from work due to pregnancy, birth or adoption of a child, or caring for a child immediately after birth or adoption, your pre-break service will be reinstated if you resume employment within 6 years after your period of service ended. Any reinstatement of pre-break service under these rules will occur only if you resume your University employment for at least one year.

Forfeiture of Non-Vested University-Funded Retirement Plan Accounts

If you leave the University before you are vested in the University-Funded Retirement Plan, the value of your University-Funded Retirement Plan account (*e.g.,* University contributions adjusted for gains and losses) will be forfeited. If you are rehired and your period of service is reinstated (see the section entitled *Effects of a Break-In-Service* above), the value of your University-Funded Retirement Plan account will be reinstated without interest. Any forfeiture will be used to reduce the University's contributions to the University-Funded Retirement Plan.

> **Example:** A participant terminates their University employment when the total value of their University-Funded Retirement Plan account (*e.g.,* University contributions adjusted for gains and losses) is $1,000. When the participant terminates employment, they have 2 years of vesting service. According to the University-Funded Retirement Plan's vesting schedule, they are 0% vested in her University-Funded Retirement Plan account because they have fewer than 3 years of service. Upon termination of employment, they will forfeit the $1,000.
>
> If the participant is reemployed before they incurs a 5-year break in service and earns one more year of service for a total of 3 years of service, they will be 100% vested in her University-Funded

Retirement Plan account and the $1,000 (the forfeited value of the University-Funded Retirement Plan account prior to the break-in-service) will be restored to their University-Funded Retirement Plan account without interest.

University-Funded Retirement Plan Loans

You may not borrow from your University-Funded Retirement Plan account.

University-Funded Retirement Plan Distributions during Employment

In general, you may not receive benefits from the University-Funded Retirement Plan while you are still employed by the University. However, if you remain employed by the University after your Normal Retirement Date (*e.g.*, your 60th birthday), you may elect to withdraw amounts from your University-Funded Retirement Plan account or to commence the benefits in accordance with the payment options available under the University-Funded Retirement Plan. Such an election is subject to spousal consent and any applicable rules of the investment vendors. See the section entitled *How Your University-Funded Retirement Plan Account Will Be Paid* for more information on the payment options available under the University-Funded Retirement Plan.

University-Funded Retirement Plan Distributions upon Termination of Employment or Retirement

Termination of Employment

If you retire at or after your Normal Retirement Date (*e.g.*, your 60th birthday), the first payment of your University-Funded Retirement Plan benefits will be made upon your completion of paperwork with the appropriate investment vendor. Please note, however, that you may not postpone the commencement of your University-Funded Retirement Plan benefits beyond *the later of* (i) April 1 of the calendar year following the year in which you retire or (ii) April 1 of the calendar year following the year in which you turn age 70½. You must begin receiving an annual minimum required distribution (calculated based on your account balance and life expectancy) on that commencement date.

How Your University-Funded Retirement Plan Account Will Be Paid

When you become eligible for a distribution, you may have the value of your vested University-Funded Retirement Plan account paid as an annuity, a lump sum payment, or in installment payments, subject to any applicable rules or restrictions of the investment vendors or the investment vehicles in which your account is invested.

Normal Form of Payment: You will automatically receive the annuity form of payment that corresponds to your marital status unless your vested account balance under the University-Funded Retirement Plan does not exceed $5,000 or you waive the annuity (in accordance with the procedures described below) and elect a lump sum or alternative form of payment.

Single Participants: If you are not married on the date your benefit is to begin under the University-Funded Retirement Plan, your retirement benefits will be paid to you in the form of a Single Life Annuity. A Single Life Annuity provides for monthly payments over your lifetime only; no survivor benefits are payable after your death. The amount of the monthly benefits payable to you will depend on the value of your vested University-Funded Retirement Plan account and your age at the time payment commences.

Married Participants: If you are married on the date your benefit is to begin under the University-Funded Retirement Plan, your retirement benefits will be paid in the form of a Qualified Joint and Survivor Annuity. A Qualified Joint and Survivor Annuity provides for monthly payments over your lifetime and 50% of the monthly payment for the lifetime of your Spouse (if they survive you). Alternatively, you may elect a Qualified Optional Survivor Annuity that provides for monthly payments over your lifetime and 75% of the monthly payment for the lifetime of your Spouse (if they survive you). The Qualified Joint and Survivor Annuity and the Qualified Optional Annuity are the actuarial equivalent of a single life annuity for your own life. The amount of the monthly benefits payable to you and your Spouse will depend on the value of your vested accounts, the ages of you and your Spouse at the time payments commence, and the percentage of the monthly benefit that you elect to continue to your Spouse after your death. Effective September 16, 2013, if you are legally married under the laws of a state that recognizes same-sex marriages, your same-sex spouse is your "Spouse" for purposes of the automatic form of payment for married participants, the spousal consent rules, death benefits, minimum distribution rules, rollover rules, and all other rules relating to Spouses and marriage under the University-Funded Retirement Plan.

Optional Forms of Payment: If you wish to waive the single life annuity or the qualified joint and survivor annuity (as applicable), you may elect to have the value of your vested University-Funded Retirement Plan account distributed in any of the following optional forms:

Annuity: You may elect to receive an annuity payable to you alone, or to you and a contingent annuitant, subject to laws and regulations regarding the maximum period over which an annuity can be paid. The annuity may be payable over a fixed period of time, or for the life or lives of you and your contingent annuitant. You may elect an annuity in any form made available by the investment vendors.

Lump Sums from CREF and Fidelity: You may elect to receive up to 100% of your accumulations in any CREF Group Retirement Annuity Contract or mutual funds, or a Fidelity Account established under the University-Funded Retirement Plan in an immediate lump-sum payment, subject to the terms and conditions of the contract or account.

Lump Sum from the Group Retirement Annuity (GRA) TIAA Traditional Annuity: You may elect to receive up to 100% of your accumulations in the GRA TIAA Traditional Annuity established under the University-Funded Retirement Plan in an immediate lump-sum payment, subject to a 2.5% surrender charge, if the cash withdrawal is elected within 120 days of the date of your termination from service. If distribution is requested more than 120 days following termination, a Transfer Payout Annuity is available (10 annual installments paid over a minimum of nine years and one day) to any variable annuity accounts or mutual funds offered through TIAA within the plan or to approved alternate carriers within the plan.

Installment Payments: You may elect to receive periodic payments from your account. You choose the amount and/or frequency of your distribution. Your installment options include quarterly, semi-annual, or annual payments. In addition, you will choose a specified regular fixed amount for each distribution or a specified period of time for distribution. The maximum period for installment payments is 20 years.

Spousal Consent

If you are married, you must obtain spousal consent in order to choose any of the optional forms of payment, to designate a beneficiary other than your Spouse, and in certain other circumstances as required by the Plan. Such spousal consent must be in writing in the form required by the Plan Administrator and must be witnessed by a notary public or plan representative. Spousal consent will not be effective until the proper documentation is delivered to the Plan Administrator. Spousal consent must be obtained within the 180- period before your payment commences to be valid.

Voluntary Distribution of Small Amounts

If your vested University-Funded Retirement Plan account does not exceed $5,000 and you leave the University, you may elect to have your balance may be distributed to you in a lump sum following your termination from employment, subject to restrictions of the investment vendors and the investment vehicles in which your account is invested.

Rollovers

In some cases (*e.g.*, a lump sum payment or payments over a period of fewer than 10 years), you may elect to have distributions that would have been paid directly to you rolled over into another employer's retirement plan or individual retirement account or annuity (IRA). Electing such a direct rollover could have important tax benefits for you. For further information about when and how University-Funded Retirement Plan distributions may be rolled over, contact the retirement vendors or Tufts Support Services (TSS).

Applying for a University-Funded Retirement Plan Distribution

When you become eligible to receive a distribution, contact the investment vendor to request distribution forms and instructions. You must complete and return your distribution forms to the Plan Administrator. Once your distribution request is approved, your vested University-Funded Retirement Plan account will be valued by the investment vendor and distributed according to your election.

Distributions after Death

When Death Benefits Will Be Paid

If you die before you receive a distribution, your vested University-Funded Retirement Plan account will be distributed to your beneficiary or beneficiaries as soon as administratively feasible following your death. Your beneficiary or beneficiaries may be able to elect a direct rollover into an IRA. For further information about when and how University-Funded Retirement Plan distributions may be rolled over, contact your investment vendor (Fidelity or TIAA) or Tufts Support Services (TSS).

How Death Benefits Will Be Paid if you Die before Distribution Commences

The manner in which death benefits under the University-Funded Retirement Plan will be distributed depends on your marital status, and if you are married, the value of your accounts at the time of the distribution.

Single Participants: If you are not married at the time of your death, your beneficiary will be entitled to receive the value of your vested University-Funded Retirement Plan account. As a rule,

your beneficiary may elect any of the optional forms of payment. See the section entitled "How Your University-Funded Retirement Account Will Be Paid – Optional Forms of Payment" above.

Married Participants: If you have been married for at least one year at the time of your death, your surviving Spouse will be entitled to receive the value of your vested University-Funded Retirement Plan account in the form of a qualified pre-retirement survivor annuity unless you and your Spouse have properly waived this form of payment (as described below). A qualified pre-retirement survivor annuity provides monthly payments over the lifetime of your surviving Spouse. The total benefit will be the actuarial equivalent of 100% of the balance credited to your University-Funded Retirement Plan account on the date of your death. The amount of the monthly payment will depend on the value of your vested University-Funded Retirement Plan account and your Spouse's age at the time payments commence. You may elect to waive the qualified pre-retirement survivor annuity and (i) have your vested University-Funded Retirement Plan account distributed to your Spouse in one of the optional forms of payment available under the University-Funded Retirement Plan, or (ii) designate any other beneficiary or beneficiaries to receive your vested University-Funded Retirement Plan account in one of the optional forms of payment available under the University-Funded Retirement Plan (see the *Beneficiary Designation* section below). You must make this election and obtain spousal consent. See the section entitled *Spousal Consent* for further information.

Your Spouse may elect to waive the qualified pre-retirement survivor annuity and have the value of your vested University-Funded Retirement Plan account distributed in one of the optional forms of payment under the University-Funded Retirement Plan if and when they become eligible for such benefit. Your Spouse makes this election when they apply for death benefits.

Your surviving Spouse will begin to receive payments of your vested account balance after your death unless they elect a later date on a form approved by and filed with the Plan Administrator.

The Plan Administrator will provide you with a detailed explanation of the qualified pre-retirement survivor annuity when you become a participant. If you waive the qualified pre-retirement survivor annuity before the first day of the Plan Year in which you reach age 35, by law that waiver will become null and void on the first day of the plan year in which you will reach age 35. At that time however, you may make another election to waive the qualified pre-retirement survivor annuity (subject to spousal consent).

How Death Benefits Will Be Paid if you Die after your Distribution Commences

If you die after distribution of your account has commenced, the form in which your account was being paid will determine whether any death benefits are payable and to whom.

Beneficiary Designations

Your beneficiary is the person(s) to whom benefits are to be paid in the event of your death. If you are married at the time of your death, your beneficiary will automatically be your surviving Spouse unless your Spouse has previously consented to the payment of your vested University-Funded Retirement Plan account to another beneficiary you have named. See the section entitled *Spousal Consent* for further information.

If you are not married at the time of your death, your vested accounts will be paid to any beneficiary that you have named with your investment vendor.

You name your beneficiary for your University-Funded Retirement Plan benefits only by completing a beneficiary designation form and submitting the completed form to your investment vendor. If you wish to change your beneficiary designation, you must contact your investment vendor. The latest form you have properly completed and provided to your investment vendor before your death will control.

You may change your beneficiary designation at any time (subject to the spousal consent rules) by contacting the investment vendor. No beneficiary designation or revocation, however, will be effective prior to its receipt by the investment vendor.

If you fail to designate a beneficiary, or if your beneficiary or beneficiaries are no longer living at the time of your death, your benefits will be distributed to your Spouse (if you are married); and if none, to your surviving issues (children and grandchildren); and if none, to your estate.

Your beneficiary designation form may include a selection of how you wish any death benefits to be distributed. In the absence of such a selection, any death benefits will be distributed in the manner selected by your beneficiary in accordance with the University-Funded Retirement Plan.

Military Leave (USERRA and Heart Act Benefits)

If you return to employment with Tufts University following a USERRA military leave, then you will not incur a break in service and you will be credited with vesting service for your period of military service. In addition, you may be entitled to receive make-up contributions to the University-Funded Retirement Plan equal to the amount of contributions that would have been made to your account if your employment with Tufts University had continued (at the same level of compensation) for the period of your military leave (reduced by any contributions actually made during the military leave period).

If you die during USERRA military service, your Spouse or other beneficiary under the University-Funded Retirement Plan may be entitled to receive Plan death benefits as if you had been re-employed by Tufts University immediately before your death. Your account will not be credited with any make-up contributions, however, for the period of your military leave. This law is effective for deaths occurring on or after January 1, 2007.

Taxes on University-Funded Retirement Plan Distributions

Under current tax laws, you defer paying federal income taxes on all contributions to the University-Funded Retirement Plan, and the investment earnings on those contributions, until your vested University-Funded Retirement Plan account is distributed to you. All distributions from the University-Funded Retirement Plan will be taxed in the year you receive payment.

Federal income tax will be withheld from the amount of any lump sum payment made to you or your surviving Spouse from the University-Funded Retirement Plan at a rate of 20%, unless the distribution is transferred directly to an individual retirement plan account ("IRA") or another employer's eligible retirement plan.

In addition, the Internal Revenue Code may impose a 10% penalty tax on any distribution you receive from the University-Funded Retirement Plan when you are under age 59½. This penalty tax will not apply if the distribution is:

- due to your disability or death;
- made after separation from service at age 55 or older;
- part of a series of substantially equal periodic payments for your life (or life expectancy) or the joint lives (or joint life expectancies) of you and your beneficiary or for a specified period of at least 10 years;
- rolled over into an IRA or another employer's eligible retirement plan;
- used to pay for unreimbursed health expenses that are greater than 10% of your adjusted gross income if you are under age 65 or 7.5% of your adjusted gross income if you or your souse is age 65 or older;
- made to satisfy a government tax levy on your account; or
- paid to an alternate payee pursuant to a qualified domestic relations order (QDRO) described below.

More information about the federal income tax treatment of your distributions will be provided to you before your University-Funded Retirement Plan account is distributed. Because the tax laws are complicated and subject to change, we recommend that you consult a professional tax advisor before making a withdrawal or taking a distribution from the University-Funded Retirement Plan.

Qualified Domestic Relations Orders (QDRO)

A QDRO is a court order assigning all or part of your retirement benefits to your Spouse, former Spouse, child or dependent to meet alimony, family support, or marital property obligations. The order must meet certain requirements to be "qualified." TIAA and Fidelity review and administer all requests for Qualified Domestic Relations Orders. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the University-Funded Retirement Plan's procedures governing QDROs.

SELF-FUNDED RETIREMENT PLAN – 403(b)

The Tufts University Self-Funded Retirement Plan can help you build savings for your retirement years. The Self-Funded Retirement Plan is a savings and investment plan that qualifies for special tax treatment. Participation in the Self-Funded Retirement Plan should be an important component of your retirement preparation, since any money you have accumulated in the Self-Funded Retirement Plan at the time you retire will be available to supplement your Social Security benefits, other retirement benefits and personal savings. Your Normal Retirement Date under the Plan is your 60th birthday.

Voluntary Employee Contributions

Under the Self-Funded Retirement Plan, you are allowed to make contributions out of your University compensation to supplement your retirement savings. These contributions are made on a pre-tax basis. This means that the money you contribute is put into the Self-Funded Retirement Plan before income taxes are withheld from your compensation. Thus, your taxable income for any given year is reduced by the amount of your Self-Funded Retirement Plan contribution for that year. Taxes are also deferred on any investment gains or losses that accumulate in your Self-Funded Retirement Plan account.

Federal law currently limits such pre-tax contributions each year. The limit for 2018 is $18,500. Further, if you are or will be at least age 50 during the year, you may contribute an additional amount of up to $6,000 for 2018. The combined pre-tax contribution limit for employees age 50 by December 31, 2018 is $24,500. The IRS issues new limits each year. Accordingly, the pre-tax limit of $18,500, the catch up limit of $6,000, and the combined limit of $24,500 may increase for 2019. If that is the case and you want to increase your pre-tax contributions for 2019, you may enter into a new Salary Reduction Agreement as described below.

All contributions to the Self-Funded Retirement Plan must be made under a Salary Reduction Agreement. You must make this Agreement with the University before Self-Funded Retirement Plan contributions can begin. Your election to make contributions will result in a reduction in your compensation for each pay period after the effective date of the Agreement. A Salary Reduction Agreement can be effective only as of the beginning of an available payroll period. You may change a Salary Reduction Agreement at any time, with respect to future compensation, on the Tufts University Benefits website at https://access.tufts.edu/get-work-done/benefits-resources/benefits or if you do not have online access, by completing the requisite form and submitting it to Tufts Support Services (TSS). A Salary Reduction Agreement may also be superseded by a later Agreement. You may not, however, submit more than one Salary Reduction Agreement per month.

Limitations

Because of restrictions imposed by federal tax law, the Self-Funded Retirement Plan contains provisions that may, in certain circumstances, further limit the amount of contributions that you might otherwise be able to make for any given tax year. Please seek advice from your tax advisor.

Self-Funded Retirement Plan Rollover Contributions

Employees are permitted to make rollover contributions (excluding any amounts includible in gross income) to the Self-Funded Retirement Plan from certain employer plans and individual retirement accounts and annuities. Any rollover contributions to the Self-Funded Retirement Plan are subject to the terms of the Self-Funded Retirement Plan. For more information about rollover contributions, please contact Tufts Support Services (TSS), or the Self-Funded Retirement Plan's investment vendors: Fidelity Investments Distribution Corporation ("Fidelity") and the Teachers Insurance and Annuity Association ("TIAA").

Your Self-Funded Retirement Plan Account

A Self-Funded Retirement Plan account will be established in your name under the Self-Funded Retirement Plan to hold your contributions and investment gains or losses.

Your Investment Options under the Self-Funded Retirement Plan

You may direct the investment of the funds in your Self-Funded Retirement Plan account in the investment options (annuity contracts and custodial accounts) offered by the Self-Funded Retirement Plan's investment vendors: Fidelity Investments ("Fidelity") and Teachers Insurance and Annuity Association ("TIAA").

Mutual Funds offered by Fidelity: You may invest your Self-Funded Retirement Plan account in custodial accounts (shares of mutual funds) offered by Fidelity or through the Fidelity platform.

Currently, a diversified choice of Fidelity mutual funds as well as other investment companies' mutual funds is available for investment of your Self-Funded Retirement Plan account. These accounts are portable – that is, if you leave the University, you may take the account with you. Alternatively, if you leave the University you may leave your vested account balance in the Self-Funded Retirement Plan until you request a distribution or until you are required by law to begin receiving distribution of your vested account balance (as a rule, April l following the later of the calendar year in which you attain age 70½ or the calendar year in which you retire from the University). In addition, you may direct the investment of your account through a participant-directed brokerage account offered through the Fidelity platform. The investment options available through a participant-directed brokerage account are limited to Fidelity and non-Fidelity mutual funds.

TIAA: You may invest your Self-Funded Retirement Plan contributions in Supplemental Retirement Annuity contracts ("SRAs") or the Group Supplemental Retirement Annuity contracts ("GSRAs") offered by TIAA. As of April 28, 2011, mutual funds offered through TIAA are no longer offered as an investment option for future contributions. If you leave the University and you are vested in the Self-Funded Retirement Plan, you may take your account with you. Alternatively, you may leave your account balance in the Self-Funded Retirement Plan until you request a distribution of your vested account balance or until you are required by law to begin receiving distribution of your vested account balance (as a rule, April 1 following the later of the calendar year in which you attain age 70½ or the calendar year in which you retire from the University).

Descriptions of all of the investment options available under the Self-Funded Retirement Plan through the investment vendors are included in separate booklets that are available online at http://fidelity.com/atwork and http://tiaa.org/tuftsuniversity. You may also request copies of these booklets by contacting the investment vendor directly. Please note that the Plan fiduciaries may add or eliminate investment options at any time in their discretion.

How Your Self-Funded Retirement Plan Account is Invested

Future Contributions

When you first become a participant in the Self-Funded Retirement Plan, your account will be invested in an age-appropriate Target Date Fund, which is the designated "default" investment for the) University-Funded Retirement Plan. You may allocate all or a portion of your account, as well as future contributions to your account, among the two investment vendors: Fidelity and TIAA. If you want to choose Fidelity as you vendor for future contributions, no action is required since they are the default vendor.

To change your vendor selection for future contributions to TIAA or split your contributions between both vendors, you must first contact TIAA to allocate up to 100% of your future contributions between the TIAA Traditional and/or CREF Stock Fund options. Contact TIAA at 800-842-2776 or log into http://tiaa.org/tuftsuniversity. Once TSS receives your investment elections from TIAA, you will be notified to login to https://access.tufts.edu/get-work-done/my-information/eserve to change your vendor selection to TIAA or designate the percentage of your contribution between Fidelity and TIAA. Until you complete both steps, 100% of your future University-Funded Retirement Plan contributions will be directed to the Plan default, the age-appropriate Target Date fund at Fidelity. Once you change your vendor election online, the change will be effective with the next available payroll.

If you do not have internet access, you may change your vendor election as to future contributions by submitting a completed Self-Funded Retirement Plan Salary Reduction Agreement form to Tufts Support Services (TSS) after you contact TIAA to make your investment elections as noted above. You may contact Tufts Support Services (TSS) to obtain this form.

If you take no action to choose a vendor or if you select Fidelity as your vendor of choice, your contributions will be invested in the Plan default, an age-appropriate Target Date fund, unless you actively choose investment allocations by contacting Fidelity at 800- 343-0860 or by logging into http://fidelity.com/atwork.

Target Date Funds provide a mix of different investments – in large and small companies, both domestic and foreign, and in both equity and fixed-income instruments – typically by investing in other mutual funds offered by the same vendor. The funds are professionally managed to target specific retirement dates, in 5-year intervals, which mean that the overall asset allocation becomes more conservative as a particular fund's target retirement date approaches. Accordingly, the risk and return characteristics of the funds vary with their target retirement dates.

Current Balances

You may change the way your current balances are invested by contacting your investment vendor directly. Transfers of past contributions credited to existing account balances are permitted to the extent allowed by law and by the terms of the investment vendors' contracts. If you wish to make a transfer between vendors, please contact the vendor to whom you wish to transfer to and they can assist you with completing the transaction.

Please note that although you may transfer your Self-Funded Retirement Plan assets among the various investment options offered under the Self-Funded Retirement Plan, you may not transfer your Self-Funded Retirement Plan assets to the University-Funded Retirement Plan or the University-Funded Retirement Plan assets to your Self-Funded Retirement Plan.

Investment Responsibility

The Self-Funded Retirement Plan is intended to constitute a plan described in Section 404(c) of the Employee Retirement Income Security Act, and Title 29 of the Code of Federal Regulations, Section 2550.404c-1. This means the Self-Funded Retirement Plan lets you choose from a broad range of investments, and you can (and have the responsibility to) decide for yourself how to invest the assets in your Self-Funded Retirement Plan account. The investment options offered by the Self-Funded Retirement Plan are broadly diversified, as to risk and return, in order to allow you to diversify your retirement savings portfolio in a manner consistent with your individual needs.

Section 404(c) provides that the fiduciaries of a plan may be relieved of liability for any losses which are the direct and necessary result of investment instructions given by a participant or beneficiary. Thus, the University, the Plan Administrator, and others responsible for the operation of the Self-Funded Retirement Plan (the Self-Funded Retirement Plan's "fiduciaries") will not be liable for any losses that are the result of investment instructions given by you, your beneficiaries, or an alternate payee. It is extremely important that you learn about the various investment options before deciding how to allocate your contributions. Before making your election, you should:

- evaluate all of your investment options carefully;
- develop a long-range personal retirement savings goal;
- decide how much risk you are willing to take to achieve your goal; and
- be aware that investments offering a greater investment return may be subject to greater risk.

To balance your risk and return effectively, you should diversify your investments. Diversifying your investments means spreading your savings among different types of investments and asset classes, such as stocks, bonds, and short-term investments such as cash. Dividing your money among several types or classes of investments with different degrees of risk and different risk characteristics means that your retirement savings will not depend on the performance of one single type of investment or asset class. No one at the University is authorized to give investment advice with respect to the Self-Funded Retirement Plan. If you have questions about investing, you should consult a professional financial advisor who can help you make decisions about your investments. However, the investment vendors can help you collect information that might assist you in making your decision.

In this regard, you are entitled to the following additional information upon request to Fidelity or TIAA, as applicable, at the addresses and telephone numbers listed on page 87:

1. Copies of any prospectuses (or, alternatively, and SEC-approved short-form or summary prospectuses), financial statements and reports and other similar materials relating to the investment funds, to the extent such information is provided to the Self-Funded Retirement Plan;

2. A list of assets comprising the portfolio of each investment fund which constitute Plan assets, the value of each such asset (or the proportion of the investment that it comprises); and

3. A statement of the value of a share or unit of each investment fund, as well as the valuation date.

The investment choices in the Self-Funded Retirement Plan include the following:

- Vanguard Target Date funds
  - This option includes professionally managed, diversified portfolios with targeted specific retirement dates, in 5-year intervals, which means that the overall asset allocation becomes more conservative as a particular fund's target retirement date approaches. Accordingly, the risk and return characteristics of the funds vary with their target retirement dates.

- Core Funds
  - Investment options include a diversified selection of funds offered by Fidelity, TIAA, and a variety of other mutual fund companies

- Fidelity Brokeragelink Accounts
  - Investment options include any of the Fidelity mutual funds not available in the Core Funds and non-Fidelity mutual funds.

Self-Funded Retirement Plan Vesting

You are always 100% vested in your Self-Funded Retirement Plan account. Being vested means you have a right to the value of your Self-Funded Retirement Plan account (*e.g.*, your contributions adjusted for investment gains and losses) when you leave the University or in certain other circumstances discussed below.

Self-Funded Retirement Plan Loans

You may borrow money from your Self-Funded Retirement Plan account to which you have made contributions only while you are an active employee. You can apply for a loan by filing the appropriate form with the applicable investment vendor. The amount you request must fall between the minimum loan amounts set by the Self-Funded Retirement Plan and the maximum loan amount permitted by law. The investment vendor can tell you what these figures are at the time you apply for a loan.

The loan will bear a reasonable rate of interest and will be secured by your Self-Funded Retirement Plan account. You will be required to make regular repayments in a manner determined by the investment vendor. The investment vendor will specify the term of your loan.

If any amount of your loan is still outstanding at the time benefits are due to be distributed to you in connection with a separation from service, any unpaid balance will immediately be due and payable in full. This unpaid balance, plus any interest accrued but unpaid, will be taken into consideration by the investment vendor when determining the benefit to which you are entitled upon separation.

If you fail to make any payment on the loan, the unpaid principal balance plus any interest accrued on your loan will immediately be due and payable in full. This unpaid principal, along with any interest accrued but unpaid, will be treated by the investment vendor as if it had been distributed to you outright. You could be liable for income taxes and penalties on the total amount that is deemed to have been distributed to you.

Self-Funded Retirement Plan Distributions during Employment

In general, you may not receive benefits from the Self-Funded Retirement Plan while you are still employed by the University. However, the following exceptions apply:

Withdrawals after Age 59½ or Upon Disability

If you have reached age 59½ or become totally and permanently disabled and thus entitled to receive benefit under the university's long term disability plan, you may request a withdrawal from your Self-Funded Retirement Plan account. Any such withdrawals will be subject to the terms of the investment options to which you have allocated contributions. If you are married, you must obtain spousal consent in order to make such withdrawals.

Hardship Withdrawals

To the extent provided by the terms of the particular investment options, you may withdraw funds in order to satisfy an immediate and heavy financial need arising from:

- uninsured health expenses incurred by you, your Spouse, or your dependents;

- costs directly related to the purchase of your principal residence (excluding mortgage payments);

- payment of tuition and education-related costs for the next 12 months of post-secondary education for you, your Spouse, or your children or dependents as defined in IRS Code Section 152;

- payments necessary to prevent your eviction from your principal residence or foreclosure of the mortgage on that residence;

- payments for burial or funeral expenses for your deceased parent, Spouse, children, or dependents as defined in IRS Code Section 152;

- expenses for the repair of damage to your principal residence that would qualify for the casualty deduction under IRS Code Section 165; or

- another immediate and heavy financial need, as determined by the Plan Administrator in accordance with law and regulations.

All hardship withdrawals are subject to spousal consent rules. Hardship withdrawals prior to age 59½ are subject to ordinary income tax plus a 10% penalty tax, unless the withdrawal is for tax-deductible health expenses or a qualified reservist distribution. Hardship withdrawals may be taken from all of the voluntary contributions you have made but may not be taken from any earnings on those contributions credited after December 31, 1988.

Qualified Domestic Relations Orders (QDRO)

A QDRO is a court order assigning all or part of your retirement benefits to your Spouse, former Spouse, child or dependent to meet alimony, family support, or marital property obligations. The order must meet certain requirements to be "qualified." TIAA and Fidelity review and administer all Qualified Domestic Relations Orders. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Self-Funded Retirement Plan's procedures governing QDROs.

Self-Funded Retirement Plan Distributions upon Termination of Employment or Retirement

Termination of Employment

When you stop working for the University, you may elect to withdraw amounts in your Self-Funded Retirement Plan account. Any such withdrawals will be subject to the terms of the investment options to which you have allocated contributions. You may request that your termination of employment benefits begin before age 60 by contacting the investment vendors and completing the required paperwork.

The University strongly encourages you not to withdraw funds from your Self-Funded Retirement Plan account until you retire, as these funds could be a critical source of retirement income for you. You are, however, fully vested in your Self-Funded Retirement Plan contributions and earnings at all times, and under some circumstances, you may begin to withdraw these funds when you are still employed by the University. Please note, however, that doing so could subject you to income taxes and penalties. Fidelity and/or TIAA can help you with any additional questions you might have regarding the implications of a

premature withdrawal from your Self-Funded Retirement Plan accounts.

Retirement

If you retire at or after your Normal Retirement Date (*e.g.*, your 60th birthday), the first payment of your Self-Funded Retirement Plan benefits will be made upon your completion of the required paperwork with the appropriate investment vendor(s). Please note, however, that you may not postpone the commencement of your Self-Funded Retirement Plan benefits beyond *the later of* (i) April 1 of the calendar year following the year in which you retire or (ii) April 1 of the calendar year following the year in which you turn age 70½. You must begin receiving an annual minimum required distribution (calculated based on your account balance and life expectancy) on that commencement date.

How Your Self-Funded Retirement Plan Account Will Be Paid

When you become eligible for a distribution, you may have the value of your Self-Funded Retirement Plan account paid as an annuity, a lump sum payment, or in installment payments, subject to any applicable rules or restrictions of the investment vendors or the investment vehicles in which your account is invested.

Normal Form of Payment. You will automatically receive the annuity form of payment that corresponds to your marital status unless your vested account balance under the Self-Funded Retirement Plan does not exceed $5,000 or you waive the annuity (in accordance with the procedures described below) and elect a lump sum or alternative form of payment.

Single Participants: If you are not married on the date your benefit is to begin under the Self-Funded Retirement Plan, your retirement benefits will be paid to you in the form of a Single Life Annuity. A Single Life Annuity provides for monthly payments over your lifetime only; no survivor benefits are payable after your death. The amount of the monthly benefits payable to you will depend on the value of your Self-Funded Retirement Plan account and your age at the time payment commences.

Married Participants: If you are married on the date your benefit is to begin under the Self-Funded Retirement Plan, your retirement benefits will be paid in the form of a Qualified Joint and Survivor Annuity. A Qualified Joint and Survivor Annuity provides for monthly payments over your lifetime and 50% of the monthly payment for the lifetime of your Spouse (if they survive you). Alternatively, you may elect a Qualified Optional Survivor Annuity, which provides for monthly payments over your lifetime and 75% of the monthly payment for the lifetime of your Spouse (if they survive you). The Qualified Joint and Survivor Annuity and the Qualified Optional Annuity are the actuarial equivalent of a single life annuity for your own life. The amount of the monthly benefits payable to you and your Spouse will depend on the value of your Self-Funded Retirement Plan account, the ages of you and your Spouse at the time payments commence, and the percentage of the monthly benefit that you elect to continue to your Spouse after your death. Effective September 16, 2013, if you are legally married under the laws of a state that recognizes same-sex marriages, your same-sex spouse is your "Spouse" for purposes of the automatic form of payment for married participants, the spousal consent rules, death benefits, loans, rollover rules, and all other rules relating to Spouses and marriage under the Self-Funded Retirement Plan.

Optional Forms of Payment: If you wish to waive the Single Life Annuity or the Qualified Joint and Survivor Annuity (as applicable), you may elect to have the value of your Self-Funded Retirement Plan

account distributed in any form permitted by the investment vendors including the following optional forms:

Annuity: You may elect to receive an annuity payable to you alone, or to you and a contingent annuitant, subject to laws and regulations regarding the maximum period over which an annuity can be paid. The annuity may be payable over a fixed period of time, or for the life or lives of you and your contingent annuitant. You may elect an annuity in any form made available by the investment vendors.

Lump Sum: You may elect to receive up to 100% of your Self-Funded Retirement Plan account in an immediate lump-sum payment, subject to the terms and conditions of the particular investment options to which you have allocated your contributions.

Installment Payments: You may elect to receive periodic payments from your account. You choose the amount and/or frequency of your distribution. Your installment options include quarterly, semi-annual, or annual payments. In addition, you will choose a specified regular fixed amount for each distribution or a specified period of time for distribution. The maximum period for installment payments is 20 years.

Spousal Consent

If you are married, you must obtain spousal consent in order to choose any of the optional forms of payment, to designate a beneficiary other than your Spouse, and in certain other circumstances as required by the Plan. Such spousal consent must be in writing in the form required by the Plan Administrator and must be witnessed by a notary public or Plan representative. Spousal consent will not be effective until the proper documentation is delivered to the Plan Administrator. Spousal consent must be obtained within the 180-period before your payment commences.

Self-Funded Retirement Plan Distribution of Small Amounts

If your Self-Funded Retirement Plan account does not exceed $1,000, your balance may be distributed to you in a lump sum without your consent following your termination from employment.

Self-Funded Retirement Plan Rollovers

In some cases (*e.g.*, a lump sum payment or payments over a period of fewer than 10 years), you may elect to have distributions that would have been paid directly to you rolled over into another employer's retirement plan or individual retirement account or annuity (IRA). Electing such a direct rollover could have important tax benefits for you. For further information about when and how Self-Funded Retirement Plan distributions may be rolled over, contact your investment vendor (Fidelity or TIAA) or Tufts Support Services (TSS).

Applying for a Self-Funded Retirement Plan Distribution

When you become eligible to receive a distribution, call your investment vendor to request distribution forms and instructions.

Self-Funded Retirement Plan Distributions after Death

When Death Benefits Will Be Paid

If you die before you receive a distribution, your Self-Funded Retirement Plan account will be distributed to your beneficiary or beneficiaries as soon as administratively feasible following your death. Your beneficiary or beneficiaries may be able to elect a direct rollover into an IRA. For further information about when and how Self-Funded Retirement Plan distributions may be rolled over, contact your investment vendor (Fidelity or TIAA).

How Death Benefits Will Be Paid

The manner in which death benefits under the Self-Funded Retirement Plan will be distributed depends on your marital status, and if you are married, the value of your accounts at the time of the distribution.

Single Participants: If you are not married at the time of your death, your beneficiary will be entitled to receive the value of your Self-Funded Retirement Plan account. Your beneficiary might be able to take the benefit in regular installments over their lifetime, or they might be required to take the benefit more rapidly. Your investment vendor (Fidelity or TIAA) can advise you regarding the maximum period of time over which death benefit payments can be spread in your particular beneficiary's situation.

Married Participants: If you have been married for at least one year at the time of your death, your surviving Spouse will be entitled to receive the value of your Self-Funded Retirement Plan accounts in the form of a qualified pre-retirement survivor annuity unless you and your Spouse have properly waived this form of payment (as described below). A qualified pre-retirement survivor annuity provides monthly payments over the lifetime of your surviving Spouse. The total benefit will be the actuarial equivalent of no less than 50% and no more than 100% (as provided in your annuity contracts and custodial accounts) of the balance credited to your Self-Funded Retirement Plan account on the date of your death. The amount of the monthly payment will depend on the value of your Self-Funded Retirement Plan account and your Spouse's age at the time payments commence.

You may elect to waive the qualified pre-retirement survivor annuity and (i) have your Self-Funded Retirement Plan account distributed to your Spouse in one of the forms of payment available under the Self-Funded Retirement Plan, or (ii) designate any other beneficiary or beneficiaries to receive your Self-Funded Retirement Plan account in one of the forms of payment available under the Self-Funded Retirement Plan (see the *Beneficiary Designation* section below). You must make this written election, and obtain written spousal consent. See the section entitled *Spousal Consent* for further information.

Your Spouse may elect to waive the qualified pre-retirement survivor annuity and have the value of your Self-Funded Retirement Plan account distributed in one of the optional forms of payment under the Self-Funded Retirement Plan if and when they become eligible for such benefit. Your Spouse makes this election when they apply for death benefits.

Your surviving Spouse will begin to receive the monthly payments after your death unless they elect a later date on a form approved by and filed with the Plan Administrator.

The Plan Administrator will provide you with a detailed explanation of the qualified pre-retirement survivor annuity when you become a participant. If you waive the qualified pre-retirement survivor annuity before you reach age 35, by law that waiver will become null and void on the first day of the plan year in which you will reach age 35. At that time however, you may make another election to waive the qualified pre-retirement survivor annuity (subject to spousal consent).

If you Die after your Distribution Commences. If you die after distribution of your account has commenced, the form in which your account was being paid will determine whether any death benefits are payable and to whom.

Beneficiary Designations

Your beneficiary is the person(s) to whom benefits are to be paid in the event of your death. If you are married at the time of your death, your beneficiary will automatically be your surviving Spouse unless your Spouse has previously consented to the payment of your Self-Funded Retirement Plan account to another beneficiary you have named. See the section entitled *Spousal Consent* for further information.

If you are not married at the time of your death, your vested accounts will be paid to any beneficiary that you have named on the Self-Funded Retirement Plan's Beneficiary Designation Form.
You name your beneficiary for your Self-Funded Retirement Plan benefits only by completing a beneficiary designation form and submitting the completed form to your investment vendor. If you wish to change your beneficiary designation, you must contact your investment vendor. The latest designation you have properly completed and provided to your investment vendor before your death will control.

You may change your beneficiary designation at any time (subject to the spousal consent rules) by filing a new form with the investment vendor. No beneficiary designation or revocation, however, will be effective prior to its receipt by the investment vendor.

If you fail to designate a beneficiary, or if your beneficiary or beneficiaries are no longer living at the time your death benefits become payable, your benefits will be distributed to your Spouse (if you are married); and if none, in equal shares to your children; and if none, to your estate.

Your beneficiary designation form may include a selection of how you wish any death benefits to be distributed. In the absence of such a selection, any death benefits will be distributed in the manner selected by your beneficiary in accordance with the Self-Funded Retirement Plan.

Military Leave (USERRA and HEART Act)

Under the Heroes Earnings Assistance and Relief Tax of 2008 ("HEART Act"), if you are ordered or called to duty as a reservist for a period of at least 180 days or an indefinite period, you may be able to take withdrawals from your Self-Funded Retirement Plan account (a "qualified reservist distribution"). There is no requirement to show hardship. The withdrawals may be subject to income tax, but not the early withdrawal 10% penalty described below. You may repay part or all of your withdrawals to the within the two-year period following your last day of active duty, even if you do not return to employment with Tufts University. The amounts repaid by you will not be treated as a new contribution to the Self-Funded Retirement Plan.

If you return to employment with Tufts University following a USERRA military leave, then you may be eligible to make up pre-tax contributions to the Self-Funded Retirement Plan equal to the maximum amount of pre-tax contributions that you could have made if your employment with Tufts University had continued (at the same level of compensation) for the period of your military leave (reduced by any pre-tax contributions actually made during the military leave period). This right applies for five (5) years following your reemployment or, if shorter, a period equal to three (3) times the period of your military leave.

Finally, if you become disabled or die during USERRA military service, you, your Spouse, or other beneficiary under the Self-Funded Retirement Plan may be entitled to receive a distribution on account of disability or Plan death benefits, whichever applies, as if you had been re-employed by Tufts University immediately before your disability or death. Your account will not be credited with any contributions that you could have made, however, for the period of your military leave. This paragraph is effective for deaths and disabilities occurring on or after January 1, 2007.

Taxes on Self-Funded Retirement Plan Distributions

Under current tax laws, you defer paying federal income taxes on all contributions to the Self-Funded Retirement Plan, and the investment gains and losses on those contributions, until your Self-Funded Retirement Plan account is distributed to you. All distributions from the Self-Funded Retirement Plan will be taxed in the year you receive payment.

Federal income tax will be withheld from the amount of any lump sum payment made to you or your surviving Spouse from the Self-Funded Retirement Plan at a rate of 20%, unless the distribution is transferred directly to an individual retirement plan account ("IRA") or another employer's eligible retirement plan. Additional taxes may be due when you file your personal income taxes at year end.

In addition, a 10% penalty tax may be imposed under the Internal Revenue Code on any distribution you receive from the Self-Funded Retirement Plan when you are under age 59½. This penalty tax will not apply if the distribution is:

- due to your disability or death;
- made after separation from service at age 55 or older;
- part of a series of substantially equal periodic payments for your life (or life expectancy) or the joint lives (or joint life expectancies) of you and your beneficiary or for a specified period of at least 10 years;
- rolled over into an IRA or another employer's eligible retirement plan;
- used to pay for unreimbursed health expenses that are greater than 10% of your adjusted gross income if you are under age 65 and 7.5% of your adjusted gross income if you or your spouse are age 65 or older;
- a qualified reservist distribution made to you while you are called up for active duty;
- made to satisfy a government tax levy on your account; or
- paid to an alternate payee pursuant to a qualified domestic relations order (QDRO) described above.

More information about the federal income tax treatment of your distributions will be provided to you before your Self-Funded Retirement Plan account is distributed. Because the tax laws are complicated and subject to change, we recommend that you consult a professional tax advisor before making a

withdrawal or taking a distribution from the Self-Funded Retirement Plan.

Qualified Domestic Relations Orders (QDRO)

All or a portion of your account may be paid to a third party pursuant to a QDRO after you benefit payments have commenced.

CLAIMS AND APPEAL PROCEDURES

If the booklets and other descriptive materials you receive from the University and benefit plan vendors contain claims and appeal procedures, please refer to the claims and appeal procedures described therein for each welfare benefit plan. Otherwise, please refer to the general ERISA claims and appeal procedures described below.

Note: Dependent Care Flexible Spending account benefits are not subject to ERISA and are therefore not subject to these claims and appeal procedures.

Claims for benefits may be made directly to the applicable Claims Administrator for the particular benefit. The Claims Administrator for the retirement plans is the University. The Claims Administrators for the welfare benefits vary by benefit and are listed in Appendix A to this booklet. When you file a claim for benefits, the Claims Administrator will advise you of any benefits to which you are entitled under the benefit plan. You may designate an authorized representative to file a claim or an appeal on your behalf. Under the Claims and Appeal Procedures, any claim, notice, statement, explanation, or determination that must be in writing may be in an electronic format, such as faxes and emails.

Denial of a Claim/Adverse Benefit Determination

Special procedures apply if you receive an adverse benefit determination. An "adverse benefit determination" is a denial of your claim, in whole or in part, a reduction in or termination of benefits, or a failure to provide payment for a benefit. For purposes of the Tufts Health Plan and the Tufts Long Term Disability Plan, an adverse benefit determination also includes any rescission of coverage (cancellation or discontinuance of coverage that has a retroactive effect). The procedures that apply may depend on the type of plan. In addition, the procedures for a Health Plan may depend on the type of claim as described below.

- An *Urgent Care Claim* is one that (i) is medically determined to require a fast decision in order to avoid seriously jeopardizing your life or health or ability to regain maximum function or (ii) in the opinion of your physician, could cause severe pain that cannot be adequately managed without the care or treatment that is subject to the claim.

- A *Pre-Service Claim* is one that requires notification or approval prior to receiving medical care.

- A *Post-Service Claim* is one that is filed for payment of benefits after care has been received. Claims for benefits under the Health Care Flexible Spending Account Plan will always be Post-Service Claims.

- A *Concurrent Care Claim* occurs when a health plan approves an ongoing course of treatment for a fixed period of time or a fixed number of treatments and (i) reconsideration results in a

reduction or termination of treatment or (ii) an extension is requested beyond the initially approved time or number of treatments.

You will receive written notification from the Claims Administrator of an adverse benefit determination within a reasonable period of time, but not later than the following:

Type of Claim	Time Limit for Claim Denial	Extension Permitted
Health Benefits*		
- Urgent Care Claims	As soon as possible, not later than 72 hours	None
- Pre-Service Claims	15 days	15 days
- Post-Service Claims	30 days	15 days
- Concurrent Care Claims	Prior to termination of care (if sufficient notice)	None
Life Insurance, Business Travel Accident Insurance, Long Term Care, University-Funded Retirement Plan, Self-Funded Retirement Plan, and Reduction in Force	90 days	90 days
Long Term Disability Benefits	45 days	up to two 30 day extensions

* Health Benefits include Health, Dental, Vision, Employee Assistance Program (EAP) and Health Care Flexible Spending Account Plans

If the Claims Administrator needs more information to make a determination on your claim, you will be notified within a reasonable period of time and the notice will describe the required information. If your Urgent Care Claim is incomplete, then you will be notified within 24 hours of filing your claim. If your Pre-Service Claim is incomplete, then you will be notified within 5 days of filing your claim. Extensions are permitted if the Claims Administrator determines that special circumstances beyond its control require an extension of time for processing the claim as described in the above table. In such case, you will be provided with written notice of the extension prior to the termination of the time for responding.

All Plans. The Claims Administrator's notice of an adverse benefit determination for all retirement and welfare plans will include the following:

- the specific reason or reasons for the adverse benefit determination;
- reference to the specific benefit plan provision on which the adverse benefit determination was based;
- a description of any additional material or information needed for you to complete the claim and an explanation of why such material is necessary; and

- a description of the benefit plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA after you have exhausted the appeals process.

Health Benefits and Disability Benefits. For claims for Health Benefits or Disability Benefits, the Claims Administrator's notice of an adverse benefit determination will **also i**nclude the following:

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the information relied upon in making the determination; or a statement that such information was relied upon in making the adverse determination, and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the benefit plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

- If the claim is for urgent care, a description of the expedited review process for urgent care claims. All necessary information with respect to an Urgent Care Claim will be provided by telephone, fax, and/or email. Notice of an adverse determination on appeal of an Urgent Care Claim may be provided orally, but written notice must be furnished not later than three (3) days after the oral notice.

The notice of an adverse determination will be provided in a culturally and linguistically appropriate manner, including how to attain access to language services or a copy in the applicable non-English language.

Disability Plan Only. Effective for Disability Benefits claims filed on or after January 1, 2018, the Claims Administrator's notice of an adverse benefit determination will **also i**nclude the following:

- a discussion of the decision, including an explanation of the basis for disagreeing with (i) health care professional and vocational professionals who evaluated and/or treated the patient, (ii) the views of medical or vocational experts that provided advice to the Plan, and (iii) a determination by the Social Security Administration; and

- a statement that the claimant is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for disability benefits.

Health Plan Only. For claims for benefits under the Tufts University Health Plan (and not the dental, vision or health Flexible Spending Account), the Claims Administrator's notice of an adverse benefit determination will also include the following:

- the date of service, health-care provider, and claim amount (if applicable), and any other information necessary to sufficiently identify the claim involved;

- diagnosis and treatment codes and their corresponding meanings or notice that you may request the codes; and

- the description of the Health Plan's review procedures will include the internal appeals and external review processes, how to initiate an appeal, and the availability of and contact information for office of health insurance consumer assistance or other party who can assist individual with internal claims and appeals and external review processes.

Appealing a Claim-Internal Appeals Process

If you receive an adverse benefit determination, you or your duly authorized representative may submit either verbally or in writing a request for reconsideration of the claim to the Claims Administrator within the following timeframe:

Type of Claim	Time Limit for Appealing Denial
Health Benefits* and Long Term Care Benefits	180 days
Life Insurance, Business Travel Accident Insurance, University-Funded Retirement Plan, Self-Funded Retirement Plan, and Reduction in Force	60 days
Long Term Disability Benefits	180 days

* Health Benefits include Health, Dental, Vision, Employee Assistance Program (EAP) and Health Care Flexible Spending Account Plans.

Any such request may be accompanied by comments, documents, records, or other information in support of the appeal. You or your representative are entitled to reasonable access to, and copies of, all documents, records and other information relevant to your claims for benefits and you have the right to review the file. You or your representative will be provided with a listing of medical or vocational experts whose advice was obtained on behalf of the benefit plan in connection with the adverse benefit determination. A failure to request a review of an adverse benefit determination will be treated as full and complete agreement with the adverse benefit determination.

Your appeal for an Urgent Care Claim may require immediate action. In these situations, you or your physician should call or e-mail the Claims Administrator as soon as possible.

Determination on Appeal

The Claims Administrator will respond within a reasonable period of time, but not later than the following:

Type of Claim	Time Limit for Appeal Denial	Extension Permitted
Health Benefits* - Urgent Care Claims - Pre-Service Claims - Post-Service Claims - Concurrent Care	 72 hours 30 days 60 days Prior to termination of care (if sufficient notice)	 None None None None
Life Insurance, Business Travel Accident Insurance, Long Term Care, University-Funded Retirement Plan, Self-Funded Retirement Plan, and Reduction in Force	60 days	60 days
Long Term Disability Benefits	45 days	45 days

* Health Benefits include the Health, Dental, Vision, Health Care Flexible Spending Account Plans and health benefits offered under the Employee Assistance Program (EAP).

If the adverse benefit determination on a claim for Health Benefits or Disability Benefits was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional and provide a decision maker who was not consulted in connection with the adverse benefit determination that is the subject of the appeal, is not the subordinate of anyone who was consulted, and who has appropriate training and experience in the field of medicine involved in the medical judgment. In making the determination on appeal, the Claims Administrator will not afford deference to the initial claim adverse benefit determination.

If the decision on appeal under the Tufts University Health Plan or Disability Plan is based on a new rationale or evidence not taken into account in your initial adverse benefit determination, then the Claims Administrator will provide to you, free of charge, the rationale or evidence sufficiently in advance of the final decision so that you can respond to the new rationale and/or evidence. In addition, you will have the right to review your claim file.

All necessary information with respect to an Urgent Care Claim will be provided by telephone, fax, and/or email.

All Plans. In its response to the appeal for any retirement plan or welfare plan, the Claims Administrator will explain, in writing, the following:

- the specific reason or reasons for the adverse benefit determination;
- specific reference to benefit plan provisions on which the adverse benefit determination is based;
- 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 for benefits;

- a statement of your right to sue under Section 502(a) of ERISA; and

- if available under a specific plan, a statement that you and your benefit plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find options that may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency. Contact information will be included.

Health and Disability Benefits. In its response to appeals involving Health Benefits or Disability Benefits, the Claims Administrator's written explanation will also include the following:

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the information relied upon in making the determination; or a statement that such information was relied upon in making the adverse determination, and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; and

- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

The notice of an adverse determination on appeal will be provided in a culturally and linguistically appropriate manner, including how to attain access to language services or a copy in the applicable non-English language.

Notice of an adverse determination on appeal of an Urgent Care Claim may be provided orally, but written notice must be furnished not later than three (3) days after the oral notice.

Disability Plan Only. Effective for Disability Benefits claims filed on or after April 1, 2018, the Claims Administrator's notice of an adverse benefit determination upon appeal will **also i**nclude the following:

- a discussion of the decision, including an explanation of the basis for disagreeing with (i) health care professional and vocational professionals who evaluated and/or treated the patient, (ii) the views of medical or vocational experts that provided advice to the Plan, and (iii) a determination by the Social Security Administration; and

- a statement that the claimant is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for disability benefits.

Health Plan Only. In response to appeals involving benefits under the Tufts University Health Plan (and not the dental, vision or health Flexible Spending Account), the Claims Administrator's notice of an adverse benefit determination will also include the following:

- the date of service, health-care provider, and claim amount (if applicable), and any other information necessary to sufficiently identify the claim involved;

- diagnosis and treatment codes and their corresponding meanings or notice that you may request the codes;

- the denial code and its meaning, as well as a description of the Plan's stand, if any, used in making the Adverse Benefit determination.

- a discussion of the adverse benefit determination; and

- the description of the Plan's review procedures will include the internal appeals and external review processes, how to initiate an appeal, and the availability of and contact information for office of health insurance consumer assistance or other party who can assist individual with internal claims and appeals and external review processes.

Exhaustion of Process/Legal Action for all Plans

You must exhaust the appeals process before you bring any legal action in a court of law or arbitration. The time limit on filing a legal claim against the plan is the later of one (1) year from the date of the adverse benefit determination on appeal.

External Review Process for the Health Plan

If you receive an adverse benefit determination under the Tufts University Health Plan and you have exhausted the internal appeals process, then you may be able to request an external review of your claim by an accredited independent review organization. The external review process applies only to an adverse benefit determination that involves (i) **medical judgment** (including, but not limited to, medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational) or (ii) **a rescission of coverage**. The external review process is not available if:

- you were not covered under the Plan at the time are or service was provided;
- the adverse benefit determination is based on your failure to meet eligibility requirements;
- you have not exhausted the internal appeals process; or
- you have not provided all required forms and information to process an external review.

You or your authorized representative must send a written request for external review to the Claims Administrator within four (4) months of the date you received the final adverse benefit determination under the Tufts University Health Plan. You must also include a copy of the notice and all other relevant information that supports your request. The Claims Administrator will conduct a preliminary review to determine if your claim is eligible for the external review process. You will not be required to pay any fees. The Plan will pay the cost of the external review process.

Expedited Request for External Review for the Health Plan

You will not be required to exhaust the applicable internal appeals process before requesting an external review if:

- the Claims Administrator has failed to make a decision within the required timeframes;

- you and the Claims Administrator agree to bypass the internal appeals process;
- your life or health is in serious jeopardy; or
- you have died.

You will be notified of the decision of the external review organization within forty-five (45) calendar days of receipt of your request form and all necessary information. If your appeal related to an Urgent Care Claim, then a decision will be made no later than seventy-two (72) hours after receipt of the request.

The Claims Administrator will abide by the decision of the external independent review organization.

CONTINUATION OF COVERAGE UNDER COBRA

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Health, Dental, Vision, Employee Assistance Program (EAP), and Health Flexible Spending Account Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under one or more of the benefit plans when they would otherwise lose their group health coverage. COBRA applies to Health, Dental, Vision, Flexible Spending Account benefits, and the Employee Assistance Program. For additional information about your rights and obligations under the plan and under federal law, contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage under a benefit plan when coverage would otherwise end because of a life event known as 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 a benefit plan is lost because of the qualifying event. Under the benefit plans, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

If you are the **Spouse** of an employee, you will become a qualified beneficiary if you lose your coverage under the benefit plan because any of the following qualifying events happens:

- your Spouse dies;
- your Spouse's hours of employment are reduced;

- your Spouse's employment ends for any reason other than their gross misconduct; or
- you become divorced from your Spouse.

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

- the parent-employee dies;
- the parent-employee's hours of employment are reduced;
- the parent-employee's employment ends for any reason other than their gross misconduct;
- the parents become divorced; 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 the University, and that bankruptcy results in the loss of coverage of any retired employee covered under a benefit plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. 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 a benefit plan.

Continuation Coverage for Same-Sex Spouses and Domestic Partners (DPs)

Effective June 26, 2013, same-sex Spouses are qualified beneficiaries under COBRA. DPs are not qualified beneficiaries under COBRA. However, the University extends rights similar to COBRA to eligible DPs. For more information, please contact Tufts Support Services (TSS).

When is COBRA Coverage Available?

The benefit plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, or death of the employee, the University must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (such as divorce of the employee and Spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify EBPA within 60 days after the qualifying event occurs.

How is COBRA 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 must be elected no later than 60 days from the later of the date of the loss of coverage caused by the qualifying event or the date the qualified beneficiary is notified of their right to COBRA continuation coverage.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event for an employee's Spouse or dependent child is the death or divorce of the employee, or a dependent

child's otherwise losing eligibility for coverage, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for their Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. This 18-month period of COBRA continuation coverage can be extended in two ways.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the benefit plan is determined by the Social Security Administration to have become disabled within 60 days of the qualifying event, and you notify the Plan Administrator within 60 days of the determination, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any dependent children receiving continuation coverage if the employee or former employee dies, or gets divorced, or if the dependent child stops being eligible under the benefit plan as a dependent child, but only if the event would have caused the Spouse or dependent child to lose coverage under the benefit plan had the first qualifying event not occurred.

Who Pays for COBRA Continuation Coverage?

The person electing continuation coverage must pay the entire cost of the applicable premium. The cost of the continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage, except in the case of disability. During the 11-month period of extended coverage for a disabled person, the cost will not exceed 150% of the applicable premium. These premiums must be paid on an after-tax basis. Under special provisions, individuals who are eligible for trade assistance (TAA eligible individuals) and individuals who receive or have a right to pension benefits from the PBGC (PBGC recipients) may receive limited government-subsidized COBRA continuation coverage.

Termination of COBRA Continuation Coverage

COBRA continuation coverage will end on the earliest of:

- the date on which the maximum period of coverage is scheduled to end (18, 29, or 36 months, whichever applies);
- the first day of the month that is more than 30 days after the date of a final determination that you or your qualified beneficiary is no longer disabled (if the maximum period of coverage is 29 months due to disability);
- the last day of the month preceding the date that you fail to make a timely COBRA payment (within 31 days of the due date);
- the date (after you have elected COBRA) that you or your dependent becomes covered under another group health plan;
- the date on which coverage is terminated for cause (*e.g.*, a fraudulent claim); or
- the date on which the University terminates all of its health plans.

The University will notify you and /or your Qualified Beneficiary if COBRA continuation coverage terminates before the end of the maximum period of coverage. In that event, you may be eligible to buy an individual plan through the Marketplace with
lower monthly premiums and lower out of pocket costs.

If You Have Questions

Questions concerning your benefit plans or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, you may also 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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

The Plan Administrator has contracted with a claims administrator for COBRA continuation coverage:

EBPA
37 Industrial Drive
Exeter, NH 03833-4593
(888) 232-3203
premiumcollection@ebpabenefits.com

You may also contact Tufts Support Services (TSS) with questions about COBRA coverage.

ADMINISTRATIVE INFORMATION

The following section contains information provided to you by the University as Plan Administrator to help you identify your benefit plans and their administrators and fiduciaries. All inquiries relating to the following information should be referred directly to the Plan Administrator.

Plan Administrator

The Plan Administrator for the benefit plans is:

Tufts University
C/o Human Resources Benefits Office 200 Boston Avenue, Suite 1600
Medford, MA 02155
(617) 627-7000

In general, the Plan Administrator is the sole judge of the application and interpretation of the benefit plans and has the discretionary authority to construe the provisions of the benefit plans, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits. However, the Plan Administrator has the authority to delegate certain of its powers and duties to a third party. The Plan Administrator has delegated certain administrative functions under some of the benefit plans to various service providers. When the Plan Administrator delegates the authority to determine claims under a benefit plan to a service provider, that service provider is the Claims Administrator for that benefit plan. As the Plan Administrator's delegate, the Claims Administrator has the authority to make decisions under the benefit plan relating to claims for benefits. Notwithstanding the foregoing, benefits under the benefit plans will be paid only if the Plan Administrator (or its delegate) decides in its discretion that the applicant is entitled to them by the terms of the plan. Claims under fully insured plans are administered by the insurance carriers.

The decisions of the Plan Administrator (or its delegate) in all matters relating to the benefit plans (including, but not limited to, eligibility for benefits, benefit plan interpretations, and disputed issues of fact) will be final and binding on all parties and generally will not be overturned by a court of law.

Amendment and Termination of Benefit Plans

The University has established the benefit plans with the bona fide intention and expectation that each will be continued indefinitely, but the University shall not have any obligation whatsoever to maintain any plan for any given length of time, and the University may at any time amend or terminate any or all of the benefit plans, in whole or in part, with respect to any or all of its participants and/or beneficiaries, by a written instrument executed by an officer of the University, or their authorized delegate.

No vested rights of any nature are provided under the welfare benefit plans (the Health, Dental, Vision, Employee Assistance Program (EAP), Flexible Spending Accounts, Life Insurance, AD&D, Business Travel Accident Insurance, Long Term Disability, Group Long Term Care Plans, and Reduction in Force Policy). Any welfare benefit claim or expense incurred before the date of any welfare benefit plan amendment or termination will be paid in accordance with the welfare benefit plan terms in effect at the time the claim or expense was incurred; provided the claim is filed with the welfare benefit plan in accordance with the applicable claims procedures and within the applicable time limits for filing such claims.

If the University decides to terminate the retirement benefit plans (the University-Funded Retirement Plan and/or the Self-Funded Retirement Plan), your interest in your account under the University-Funded Retirement Plan, if not already vested, will become vested. Your annuity contracts and custodial accounts under the Self-Funded Retirement Plan will remain vested. All of these amounts will be used to provide benefits in accordance with the provisions of the retirement benefit plan documents. If any material modifications are made to the retirement benefit plans, you will be notified.

Additional Information - Plan Sponsor

The plan sponsor of your employee benefit plans is:

Tufts University
C/o Human Resources Benefits Office 200 Boston Avenue, Suite 1600
Medford, MA 02155
(617) 627-7000

The names and addresses of any other employers that have adopted the Plan, if any, may be obtained from the Plan Administrator.

Employer Identification Number

The University's employer identification number (EIN) is: 04-2103634

Agent for Service of Legal Process

The Plan Administrator is the designated agent for service of legal process on the benefit plans. In addition, if a dispute arises over retirement benefits under the University-Funded Retirement Plan, legal process also may be served on any trustee of the University-Funded Retirement Plan. Finally, if a dispute arises over health benefits under the Health Plan, legal process also may be served on any trustee of the Tufts University Employee Benefits Trust.

Plan Year

The financial records of the benefit plans are kept on a plan year basis beginning on each January 1 and ending on each December 31. The financial records of the Tufts University Employee Benefits Trust are kept on the fiscal year, July 1 – June 30.

Plan Names, Types, and Numbers

Welfare Plans Plan Name(s)	Plan Number
Tufts University **Group Welfare Benefit Plan**, including --Tufts University Group Term Life/AD&D Insurance Plan --Tufts University Group Long Term Disability Plan --Tufts University Flexible Spending Account Plan --Tufts University Dental Plan --Tufts University Health Benefit Plan --Tufts University Group Long Term Care Plan --Tufts University Vision Care Plan --Tufts University Employee Assistance Program (EAP) --Tufts University Reduction in Force Policy --Tufts University Business Travel Accident Plan	501
Retirement Plans Plan Name(s)	Plan Number
Tufts University Self-Funded Retirement Plan-403(b) Tufts University University-Funded Retirement Plan – 401(a)	001 002

Refund of Overpayments

Whenever a payment has been made under any benefit plan in a total amount, at any time, in excess of the maximum amount payable under the plan's provisions ("Overpayment"), you or any other person for whom the payment was made must refund the applicable Overpayment to the plan and/or help the plan obtain the refund of the Overpayment from another person or organization. This includes any Overpayments resulting from retroactive awards received from any source, fraud, or any error made in processing your claim.

In case of a recovery from a source other than the plan, Overpayment recovery will not be more than the amount of the payment. An Overpayment also occurs when payment is made from the plan that should have been made under another group plan. In that case, the plan may recover the payment from one or more of the following: any other insurance company, any other organization, or any person to or for whom payment was made.

The plan may, at its option, recover the Overpayment by reducing or offsetting against any future benefits payable to you and/or your family members; stopping future benefit payments that would otherwise be due under the plan (payments may continue when the Overpayment has been recovered);

or demanding an immediate refund of the Overpayment from you or any other person for whom the payment was made.

With respect to long term disability, the Plan Administrator also reserves the right to recover funds related to disability benefits for any Overpayment when you also receive state benefits, including Workers' Compensation and Social Security benefits, or other types of income listed in the applicable Welfare Benefit Contract.

Reimbursement – Health and Dental Plans

This section applies when you or your covered family member ("Covered Person") recovers damages - by settlement, verdict, or otherwise - for an injury, sickness, or other condition for which benefits may also be payable under the Health Plan and/or Dental Plan. If the Covered Person has made - or in the future may make - such a recovery, including a recovery from an insurance carrier, the plan will not cover either the reasonable value of the services to treat such an injury or illness or the treatment of such an injury or illness.

However, if the plan does pay for or provide benefits for such an injury, sickness, or other condition, by accepting such benefits, the Covered Person agrees that they, or their legal representatives, estate, or heirs, will promptly reimburse the Plan for all recovery amounts (whether or not characterized as related to health expenses) from any settlement, verdict, or insurance proceeds received by the Covered Person (or by the legal representatives, estate, or heirs of the Covered Person) to the extent that health benefits have been paid for or provided by the Plan to the Covered Person.

If the Covered Person receives payment from a third party or their insurance company because of an injury or harm due to the conduct of another party and the Covered Person has received benefits from the plan, the plan must be reimbursed first. In other words, the Covered Person's recovery from a third party may not compensate the Covered Person fully for all the financial expenses incurred because acceptance of benefits from the plan constitutes an agreement to reimburse the plan for any benefits the Covered Person receives.

The Covered Person also must take any reasonably necessary action to protect the plan's subrogation and reimbursement rights. This means that, by accepting benefits from the plan, the Covered Person agrees to notify the Plan Administrator if and when the Covered Person institutes a lawsuit or other action or enters into settlement negotiations with another party (including their insurance company) in connection with or related to the conduct of another party.

The Covered Person also must cooperate with the Plan Administrator's reasonable requests concerning the plan's subrogation and reimbursement rights and must keep the Plan Administrator informed of any important developments in their action. The Covered Person also agrees that the Plan Administrator may withhold any future benefits paid by the Health and/or Dental Plan (or any other disability or health plan maintained by Tufts University) to the extent necessary to reimburse the plan under the plan's subrogation or reimbursement rights.

To secure the rights of the plan under this section, each Covered Person hereby:

- Grants to the plan a first-priority lien against the proceeds of any such settlement, verdict, or other amounts received by the Covered Person to the extent of all benefits provided in an effort to make the plan whole;

- Assigns to the plan any benefits the Covered Person may have under any automobile policy or other coverage; the Covered Person shall sign and deliver, at the request of the plan or its agents, any documents needed to protect such lien or to effect such assignment of benefits; and

- Will cooperate with the plan and its agents and will:

    - Sign and deliver such documents as the plan or its agents reasonably request to protect the plan's right of reimbursement;

    - Provide any relevant information; and

    - Take such actions as the plan or its agents reasonably request to assist the plan in making a full recovery of the value of the benefits provided.

If the Covered Person does not sign and deliver any such documents for any reason (including, but not limited to, the fact that the Covered Person was not given an agreement to sign or is unable or refuses to sign), the Plan Administrator, in its sole discretion, may or may not advance benefits to the Covered Person under the plan.

If the Plan Administrator has advanced benefits, it has the right to subrogation and reimbursement whether or not the Covered Person has signed the agreement. The Covered Person shall not take any action that prejudices the plan's right of reimbursement.

Subrogation – Health and Dental Plans

This section applies when another party is, or may be considered, liable for a Covered Person's injury, sickness, or other condition (including insurance carriers that are so liable), and the Health Plan and/or Dental Plan has provided or paid for benefits.

The plan is subrogated to all the rights of the Covered Person against any party, including any insurance carrier, liable for the Covered Person's injury or illness or for the payment for the medical treatment of such injury or occupational illness to the extent of the value of the health benefits provided to the Covered Person under the plan. The plan may assert this right independently of the Covered Person.

The Covered Person is obligated to cooperate with the plan and its agents to protect the plan's subrogation rights. Cooperation means providing the plan or its agents with relevant information requested by them; signing and delivering such documents as the plan or its agents reasonably request to secure the plan's subrogation claim; and obtaining the consent of the plan or its agents before releasing any party from liability for payment.

If the Covered Person enters into litigation or settlement negotiations regarding the obligations of other parties, the Covered Person must not prejudice, in any way, the subrogation rights of the plan under this section. Further, the Covered Person agrees to notify the Plan Administrator if and when the Covered Person institutes a lawsuit or other action or enters into settlement negotiations with another party (including their insurance company) in connection with or related to the conduct of another party.

The costs of legal representation retained by the plan in matters related to subrogation shall be borne solely by the plan. The costs of legal representation retained by the Covered Person shall be borne solely by the Covered Person.

Administration of Welfare Plans

The vendors and Claims Administrators for the welfare plans are listed in Appendix A to this booklet.

Employee Benefits Trust Trustees

The benefits under the Health Plan are financed by contributions from the University and from Health Plan participants. Beginning January 1, 2018, amounts needed to pay the University's share of premiums/benefits under the Plan, may, in the sole discretion of the University, be paid from the University's general assets or from assets in a separate account in the Tufts University Employee Benefits Trust. No participant, dependent, or other individual has an interest in or any right to assets held in the Trust.

The Trustees of the Tufts University Employee Benefits Trust are:

Thomas B. McGurty, Vice President of Finance and Treasurer
Susan Leverone, Senior Director, Financial Planning
Robbyn W. Dewar, Benefit Programs and Compliance Director
Tufts University
200 Boston Avenue, Suite 1600,
Medford, MA 02155

Privacy of Health Information

A federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires group health plans to protect the confidentiality of your private health information. The privacy provisions of HIPAA apply to the Health, Dental, Vision, Employee Assistance Program (EAP) and Health Care Flexible Spending Account Plans.

The group health plans and the University, as sponsor of such plans, receive and maintain information that is protected by HIPAA ("protected health information") in the course of providing benefits to you. Your protected health information includes demographic information that may identify you and relates to (i) health care services provided to you, (ii) payment for health care services provided to you, or (iii) your physical or mental health or condition, in the past, present, or future. This includes documentation that reveals your identity and your health status or payment issues, such as medical records, medical bills, claims data, and payment information.

The group health plans and the University will not use or further disclose your protected health information except as necessary for treatment, payment, health plan operations, and plan administration, or as otherwise permitted or required by applicable law. Some uses and disclosures may be made without your consent, including disclosures to government agencies for health oversight activities, workers' compensation, and law enforcement. Other disclosures may be made only with your written authorization, such as marketing communications that encourage you to purchase or use a

specific product or service. When using or disclosing protected health information, the group health plans will strive to limit the protected health information to the minimum necessary to accomplish the intended use, disclosure, or request. In particular, the group health plans will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the University.

By law, the group health plans will require all of their business associates (and their agents) to observe HIPAA's privacy rules. Business associates include certain service providers to the group health plans, such as claims administrators, COBRA Administrators, and auditors, that receive and use protected health information to carry out their responsibilities to the plans.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the applicable group health plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. No one will discriminate against you or take any retaliatory actions for exercising your rights under HIPAA, provided you have a good faith belief that an act or practice violates HIPAA, you act in a reasonable manner, and do not disclose protected health information in violation of HIPAA.

The group health plans maintain a privacy notice that provides a complete description of your rights under HIPAA's privacy rules and the permitted uses and disclosures of protected health information. The notice will be provided for you at the intervals provided by law. In addition, you can find the notice on the University's benefits intranet site at http://hr.tufts.edu/benefits/. For a paper copy of the notice at any time, please contact Tufts Support Services (TSS). If you have questions about the privacy of your health information, please contact Tufts Support Services (TSS) or the University's designated Privacy and Security Officer identified in the notice.

Security of Health Information

HIPAA also includes security rules for electronic health information. The University has implemented safeguards to protect the confidentiality, integrity and availability of electronic protected health information, implement security measures to ensure adequate separation between the University and the benefit plans, and ensure that any agent to whom it provides electronic protected health information also agrees to implement reasonable and appropriate security measures. The University will report to the group health plans any security incident of which it becomes aware involving electronic protected health information.

Privacy and Security Procedures

The University has implemented procedures to ensure the privacy and security of your protected health information. The University has appointed a Privacy and Security Officer to oversee development and implementation of procedures, compliance with procedures, and the training of the University's workforce.

Notice of Privacy or Security Breach

You will be notified if there is Breach of your unsecured protected health information. A Breach occurs if an unauthorized acquisition, access, use, or disclosure of your protected health information that compromises the security or privacy of such information. The group health plans have implemented risk assessment standards to determine when the security or privacy of unsecured protected health information has been compromised.

Administration of Retirement Plans

The Retirement Plans, the University-Funded Retirement Plan and the Self-Funded Retirement Plan, are defined contribution plans that are intended to provide income to you when you no longer are employed. The University-Funded Retirement Plan is a money purchase pension plan qualified under Section 401(a) of the Internal Revenue Code. Under the Self-Funded Retirement Plan, annuity contracts and custodial accounts described in Section 403(b) of the Code are established by the University with employees' pre-tax contributions.

The Retirement Plans are administered by the Plan Administrator. Assets under the University-Funded Retirement Plan are held in a trust and invested with TIAA and Fidelity. Assets under the Self-Funded Retirement Plan are held in annuity contracts by TIAA and in custodial accounts by Fidelity.

The University makes all contributions under the University-Funded Retirement Plan. The employee makes all contributions under the Self-Funded Retirement Plan.

University-Funded Retirement Plan Trustees

Thomas S. McGurty, Vice President of Finance and Treasurer
Julien Carter, Vice President for Human Resources
Robbyn Dewar, Benefits Programs and Compliance Director
Tufts University
200 Boston Avenue, Suite 1600
Medford, MA 02155

Annuity Company

Teachers Insurance and Annuity Association (TIAA)
730 Third Avenue
New York, NY 10017
(212) 490-9000

Custodian

Fidelity Investments Management Trust Company
82 Devonshire Street
Boston, MA 02109
(617) 563-7000

Pension Plan Insurance

Benefits under the University-Funded Retirement Plan and the Self-Funded Retirement Plan are not insured by the Pension Benefit Guaranty Corporation, because the University-Funded Retirement Plan is a "defined contribution" plan and the Self-Funded Retirement Plan is a "403(b)" plan. The benefit you receive from the University-Funded Retirement Plan will depend on how long you work for the University, the amount that the University contributes (which is based on your earnings and age), and the investment performance of your accounts. The benefit you receive from the Self-Funded Retirement Plan will depend on the amount you contribute to the Self-Funded Retirement Plan and the investment performance of your accounts. Federal law does not provide termination insurance for defined contribution plans and plans.

Non-Assignment of Benefits

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under any of the University's benefit plans, and any attempt to do so will be void, except as otherwise required or permitted by law, such as when required by a Qualified Domestic Relations Order (QDRO) or a Qualified Medical Child Support Order (QMSCO). The payment of benefits directly to a health care provider, if any, will be done as a convenience to the Covered Person and shall not constitute an assignment of benefits under any benefit plan.

No Employment Rights

Nothing in this booklet, the Plan, the benefit plans, the Welfare Benefit Contracts, or any other related document creates an employment contract or any right to continued employment at the University.

Union Agreements

The benefit plans are maintained, in part, pursuant to one or more collective bargaining agreements. If you are covered by a collective bargaining agreement and you receive benefits under one or more of the benefit plans pursuant to the collective bargaining agreement, you may obtain a copy of the collective bargaining agreement that covers you at any reasonable time at the office of the Plan Administrator.

Reliance on Tables

In administering the Plan, the Plan Administrator is entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions or recommendations of accountants, counsel, actuaries, consultants or other experts employed or engaged by the Plan Administrator.

Indemnification of Administrator

The University agrees to indemnify and to defend to the fullest extent permitted by law any employee or participating employer serving as the Plan Administrator or as a member of a committee designated as Plan Administrator (including any employee or former employee who formerly served as Plan Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the University) occasioned by any act or omission or act in connection with the Plan, if such act or omission is in good faith.

YOUR RIGHTS AS A PLAN MEMBER

As a participant in the Health, Dental, Vision, Employee Assistance Program (EAP), Health Care Flexible Spending Account, Life Insurance, AD&D, Business Travel Accident Insurance, Long Term Disability Insurance, Group Long Term Care Plan, University-Funded Retirement Plan, Self-Funded Retirement Plan, and/or the Reduction in Force Policy (if you become a participant), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). Dependent care flexible spending account benefits are not subject to ERISA and are therefore not subject to this section. Employees become participants in the Reduction in Force Policy if they experience an involuntary termination of employment that is a reduction in force and satisfy other eligibility requirements under the Policy. ERISA provides that all benefit plan participants are entitled to:

Receive Information about the Plan and Benefits

- Examine, free of charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the benefit plans, including insurance contracts and collective bargaining agreements and a copy of the latest annual reports (Form 5500 series) filed by the benefit plans with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. These documents are also available for review at Tufts Support Services (TSS).

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the benefit plans, including insurance contracts and copies of the latest annual reports (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may charge a reasonable fee for copies.

- Receive a summary of a plan's annual financial reports. The Plan Administrator is required by law to furnish each participant a copy of these Summary Annual Reports.

- Obtain, upon written request, an annual statement of your vested benefit under the University-Funded Retirement Plan and the Self-Funded Retirement Plan. This statement will tell you whether you have a right to receive a pension at your Normal Retirement Date (age 60) and if so, what your benefits would be at your Normal Retirement Date if you stop working under the Plan now. If you don't have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. It will be provided free of charge but is not required to be provided more than once every twelve (12) months.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under health plans as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review these summary plan descriptions and the documents governing the health plans on rules governing your COBRA coverage.

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 plans described in this booklet. These people who operate your plan, called "fiduciaries" of the plan have a duty to so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against in any way to prevent you from obtaining a retirement or welfare benefit or exercising your rights under ERISA.

The Plan Administrator is a 'named fiduciary' with respect to each benefit plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the plan. These other persons become fiduciaries themselves and are responsible for their acts under the plan. To the extent that the named fiduciary allocates its responsibility to another person, the named fiduciary will not be liable for any act or omission of such person unless either (i) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures or (ii) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

Fiduciary Duties

A fiduciary must carry out their duties and responsibilities for the purpose of providing benefits to Eligible Employees and their Eligible Dependents and beneficiaries and defraying reasonable expenses of plan administration. These duties must be carried out with the care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation and in accordance with plan documents to the extent that they are consistent with ERISA.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of the plan documents or the latest annual report (or other materials that you have a right to receive) and do receive them within 30 days of your request, you may file a suit in a federal court. The court may require the Plan Administrator to provide the materials and pay up to $110 for each day's delay until you receive the materials (unless the materials were not sent for reasons beyond the control of the Plan Administrator).

If you have a claim for benefits that is denied or ignored, in whole or in part, you have a right to know why it was denied or ignored, to obtain copies (without charge) of documents relating to the decision, and to appeal any denial or other adverse benefit determination within certain timeframes. You also have the right to file suit in a federal or state court. In addition, if you disagree with a decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order under a benefit plan, you may file suit in federal court. If plan fiduciaries misuse a benefit plan's money or 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 in your suit, the court may order the person you have sued to pay court costs and legal fees. If you lose, the court may order you to pay the costs and fees if, for example, it finds your claim are frivolous.

Assistance with Your Questions

If you have any questions about a benefit plan, 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. If you reside in Massachusetts, the nearest office of the Employee Benefits Security Administration is the Boston Regional Office, J.F.K. Building, Room 575, 15 New Sudbury Street, Boston, MA 02203, telephone (617) 565-9600. You may also 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 at the Employee Benefits Security Administration.

APPENDIX A - Welfare Plans - Benefit Plan Vendors

Coverage	Status	Claims Administrator/Insurer
Health	Self-Insured PPO plan	Tufts Health Plan 705 Mount Auburn Street Watertown, MA 02472-1508
Dental	Self-Insured	Delta Dental Plan of Massachusetts 465 Medford Street Boston, MA 02129
Employee Assistance Program	Fully-Insured	AllOne Health Management Solutions The Summer Exchange Building 101 Arch Street, Suite 20 Boston, MA 02110
Vision	Fully-Insured	EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040
Flexible Spending Accounts	Funded by Employee contributions	EBPA 37 Industrial Drive Exeter, NY 03833
Life Insurance and Accidental Death and Dismemberment Insurance	Fully-Insured	The Prudential Life Insurance Company of America 751 Broad Street Newark, NJ 0710
Long Term Disability	Fully-Insured	The Prudential Life Insurance Company of America 751 Broad Street Newark, NJ 0710
Long Term Care (Effective 4/1/2009 through 06/01/2013)	Fully-Insured	The Prudential Life Insurance Company of America 751 Broad Street Newark, NJ 07102
Reduction in Force Policy	Self-Insured	Tufts University
Business Travel Accident Policy	Fully-Insured	Chubb /Federal Insurance Company

The vendors listed above (in Appendix A) for coverages that are self-funded (not insured) provide certain administrative services for the relevant plans. These vendors provide claims payment and other administrative services under an administrative services contract with the University, but they do not assume any financial risk or obligation with respect to claims or benefits under the relevant plans. The vendors listed above for coverages that are fully insured provide benefits under one or more insurance policies or contracts issued to the University. These vendors are solely responsible for financing and providing the benefits under the insurance policies and contracts. The University has no liability for any benefits due or alleged to be due, under any such insurance policies or contracts.

APPENDIX B – Grandfathered Plan Status

Prior to January 1, 2015, the Tufts Health Plan was a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, the Health Plan did not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. Effective January 1, 2015, the Tufts Health Plan changed its status to comply with all of the protections required under the Affordable Care Act.

You may contact the Plan Administrator if you have questions about the Health Plan's change in status. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or online at www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

GLOSSARY OF TERMS

Open Enrollment Period: means the annual period during which you are given the opportunity to review and make changes to your benefit coverage elections (usually in October) for the next plan year (1/1 – 12/31).

Breach: means an unauthorized acquisition, access, use, or disclosure of protected health information that compromise the security or privacy of such information.

CHIP*:* means a state Children's Health Insurance Program.

COBRA: means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

COBRA Administrator: means the party who administers COBRA continuation coverage under a contract with the University.

Conversion rights: allow employees to convert their group term life policy to an individual whole life policy and their long term disability coverage to an individual policy upon termination of employment.

Covered Person: means a Participant as well as any Eligible Dependent or beneficiary who is or becomes covered under one or more benefit plans.

Deductible: means a fixed dollar amount during the benefit period – usually a year – that an insured person pays before the insurer starts to make payments for covered medical services. Plans may have both per individual and per family deductibles, separate deductibles for specific services and deductibles may differ if services are received from an approved provider or if received from providers not on the approved list.

Domestic Partner (DP): means an individual with whom you have entered into a domestic partnership that meets all of the following criteria: having an exclusive mutual commitment similar to that of marriage; residing in the same household; being financially responsible for each other's well-being and debts to third parties; neither party being married to anyone else nor having another domestic partner receiving benefits; and the partners not being related by blood to a degree that would bar marriage in the state of their residence. Employees must have a signed 'Affidavit of Qualified Domestic Partnership' that certifies that the partnership meets the University's requirements.

EAP: means Employee Assistance Program.

Eligible Employee: Refer to the Eligibility section of this booklet.

Eligible Dependents: Refer to the Eligibility section of this booklet.

EBSA: means the Employee Benefits Security Administration

ERISA: means the Employee Retirement Income Security Act of 1974, as amended from time to time.

FMLA: means the Family and Medical Leave Act of 1993, as amended from time to time.

FSA: means Flexible Spending Account (Health Care and/or Dependent Care).

GINA: means the Genetic Information Nondiscrimination Act of 2008.

Health Care Reform: means the Patient Protection and Affordable Care Act, 2010 and the Health Care and Education Reconciliation Act of 2010.

HEART Act: means the Heroes Earnings Assistance and Relief Tax of 2008.

HIPAA: means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Human Resources Benefits Department: means the Tufts University Human Resources Benefits Office located at 200 Boston Avenue, Suite 1600, Medford, MA 02155.

Maximum Out of Pocket Expense: means the maximum dollar amount a group member is required to pay out of pocket during a year. Until this maximum is met, the plan and group member share in the cost of covered services. After the maximum is reached, the plan pays all covered expenses.

MHPA: means the Mental Health Parity Act of 1996 and the Mental Health Parity and Addiction Equity Act, as amended from time to time, and regulations and other formal guidance issued thereunder.

Michelle's Law: means a part of ERISA that allows full-time, seriously ill or injured college students who are covered under their parent's health insurance plan to take up to one year of medical leave without losing their health insurance.

Overpayment: occurs whenever a payment has been made under any benefit plan in a total amount, at any time, in excess of the maximum amount payable under the plan's provisions.

Participant: means an Eligible Employee who is enrolled in or covered by a welfare benefit plan or retirement plan, as the case may be. An Eligible Employee becomes a Participant in a particular plan either automatically or through their enrollment, depending on the terms of the plan.

Portability: is a right under the current group term life insurance policy that allows employees to continue their coverage upon termination of employment.

Protected Health Information or PHI: means "Protected Health Information" under the HIPAA Privacy Rule. Protected Health Information is defined in 45 C.F.R. §164.501, and includes demographic information, that may identify you and relates to (i) health care services provided to you, (ii) payment for health care services provided to you, or (iii) your physical or mental health or condition, in the past, present, or future. It includes your genetic information.

Plan: means the Tufts University Group Welfare Benefit Plan (Plan Number 501) as set forth herein (including any and all amendments and supplements hereto) and the Welfare Benefit Contracts, which are incorporated by reference into this document.

Plan Administrator: means Tufts University or such other person or committee as may be appointed from time to time in the future by the University to supervise the administration of the Plan.

Preferred Provider Organization (PPO): is a managed care organization of medical doctors, hospitals, and other health care providers who have agreed with a third-party administrator (such as Tufts Health Plan) to provide health care at reduced rates to the administrator's clients.

QDRO: or "Qualified Domestic Relations Order" means a court order assigning all or part of your retirement benefits to a Spouse, ex-Spouse, child or dependent to meet alimony, family support, or marital property obligations that also meets certain requirements under ERISA.

QMCSO: or "Qualified Medical Child Support Order" means a court order requiring you to provide specified health care coverage for your child or dependent that also meets certain requirements under ERISA.

Spouse: means effective June 26, 2013 a legal spouse, including a same-sex spouse to whom you are legally married under the laws of a state that recognizes same-sex marriages, regardless of where you reside. You are not treated as legally married if you have entered into a registered domestic partnership, civil union, or other formal relationship under state law that is not a marriage. A qualified same-sex domestic partner may be treated as a Spouse for purposes of coverage under plans that provide benefits for Spouses but is not treated as a Spouse where tax laws require legal marriages. For example, a DP is not a "Spouse" for purposes of the Flexible Spending Accounts, the University-Funded Retirement Plan, and the Self-Funded Retirement Plan.

SSA: means the United States Social Security Administration.

Subrogation: refers to certain rights of the Health and Dental Plans when another party is, or may be considered, liable for a Covered Person's injury, sickness or other condition (including insurance carriers that are so liable) and the Plan has provided or paid for benefits.

Tufts Support Services (TSS): Is a centralized service center made up of Tufts Employees who deliver a high level of service for transactional Finance and Human Resources services to Tufts faculty, staff and student-employees. Their goal is to provide support to individuals and departments, so faculty and staff can focus more of their efforts on other work that advances their core mission and goals. There are physical locations on all three campuses.

University: means Tufts University and any successor to all or a major portion of its assets or business that assumes the obligations of Tufts University under the Plan.

USERRA: means the Uniformed Services Employment and Reemployment Rights Act of 1994.

Welfare Benefit Contract: means any contractual arrangement maintained by the University, and described on Appendix A, under which group health or other welfare benefits are made available to eligible employees and their eligible dependents, including any separate plan document for a particular benefit and the insurance or other contracts, policies, agreements and other documents that set forth the benefit descriptions, types, amounts, payment rules, limitations and exclusions, and other terms and conditions that are applicable under a particular welfare benefit plan.

WHCRA: means the Women's Health and Cancer Rights Act of 1998.