

Tufts University

Retiree Dental Benefits Plan

Amended & Restated

January 1, 2018

The University reserves the right to amend this Plan at any time without the consent of any eligible employee, participant, or dependent. Although the University expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan coverage at any time without liability.

**TUFTS UNIVERSITY
RETIREE DENTAL BENEFITS PLAN**

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INTRODUCTION

Tufts University is happy to offer you and your eligible family members retiree dental coverage through Delta Dental. Every effort has been made to describe the Tufts University Retiree Dental Benefits Plan (the “Plan”) accurately, completely and in easy-to-read language. This booklet provides an overview of Tufts University’s requirements for participation in the Plan and is intended to be only a summary.

Please refer to the related description of benefits and your subscriber certificate for complete details on specific benefit coverage, definitions, exclusions, and limitations. These important documents are incorporated by reference in this booklet.

To achieve the highest degree of coverage in the event of any injury or illness, as well as allowing you to manage your dental care expenses, you must follow the predefined terms and conditions of the dental plan. Remember that if these provisions are not followed as described, benefits may be reduced or denied.

This Plan is intended to be a separate plan that provides dental benefits and is exempt from the provisions of the Patient Protection and Affordable Care Act.

ELIGIBILITY

For Yourself

You are eligible to participate in the Plan if, at retirement, you are at least age 60 and have 5 or more years of service with Tufts University; or your age plus years of service with Tufts University equals at least 75. Only benefits-eligible employment, as determined under the Tufts University Health Benefits Plan, will be counted towards years of service. If you retired prior to January 1, 2018, this Plan required you to (i) be covered for retiree health benefits under the Tufts University Retiree Health Insurance Plan or (ii) elect coverage within 31 days following your retirement date.

For Your Eligible Dependents

You may enroll your eligible dependents in the Plan only if you elect coverage for yourself. Your eligible dependents include your spouse, your qualified domestic partner, and your eligible children.

Your eligible “children” include:

- your biological children,
- your legally adopted children,
- your stepchildren who live with you full time in a regular parent-child relationship,
- your foster children, 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 his/her 26th birthday. However, if your child is disabled and age 26 or over, he or she may be covered under the Plan only if the child (i) was enrolled when first eligible to participate and (ii) is incapable of self-sustaining employment due to a disability. The Plan Administrator may require documentation of initial and continued disability.

Dependents are eligible to participate at the same time or times that apply to you. See the Enrollment section, below for details.

In this booklet, the term “dependent” will refer to a spouse, a qualified domestic partner, and/or eligible children.

ENROLLMENT

You and your dependents, if eligible, may enroll for Retiree dental benefits under the Plan when you first retire by enrolling through the Plan Administrator within 31 days of your retirement. Effective for Retirees who retire on or after January 1, 2018, you must enroll in coverage within 31 days of your retirement or **you and your dependents will irrevocably forfeit any right to participate in dental coverage under the Plan in the future.**

If you retired prior to January 1, 2018, and you and your eligible dependents did not enroll in coverage under the Plan at the time of your retirement, you have a one-time opportunity to join the Plan during the 2018 annual Open Enrollment period. **If you or your eligible dependents are not enrolled in dental coverage as of January 1, 2018, you and your dependents will irrevocably forfeit any right to participate in dental coverage under the Plan in the future.**

RETIREE DENTAL BENEFITS

Please refer to the related description of benefits and your subscriber certificate for complete details on specific benefit coverage, definitions, exclusions, and limitations.

EFFECTIVE DATE

Coverage will coincide with your retirement date or, if you elect coverage during an Open Enrollment period, January 1 of the following year.

COST

Premiums are determined annually (by Tufts University in its sole discretion) and are fully paid by the retiree.

WHEN COVERAGE ENDS

Coverage for you and your eligible dependents under the Tufts University Retiree Dental Benefits Plan ends on the earliest of the following dates:

- The date the Plan terminates;
- The date you cease to be eligible for coverage under the Plan (including, but not limited to, cessation of eligibility due to a Plan amendment or partial Plan termination);
- The date you fail to pay a required contribution for coverage by the applicable date;
- The date you voluntarily elect to discontinue your coverage under the Plan. **If your coverage ends for this reason, or because you fail to pay a required contribution, you cannot subsequently re-enroll in the Plan;**
- The date of your death; however, your eligible dependents will continue to be covered under the Plan, as long as they meet the Plan's eligibility requirements and their coverage does not end for one of the reasons listed here; or
- If your dependents are no longer eligible for coverage because of a divorce, the ending of a domestic partnership, or your dependent child reaching the limiting age of 26; however, your affected dependent(s) may be eligible to continue coverage under COBRA for up to 36 months by paying the entire cost, plus an administrative fee, for coverage.

CLAIM PROCEDURES AND APPEALS

Claims Processing

Under certain circumstances, you may be required to file a claim form to obtain benefits. Under other circumstances, dental providers will submit claims for you. If any benefits under the Plan are denied, you have the right to request a full and fair review of your claim within the timeframes set out in the claims procedures. If you believe you are incorrectly denied all or part of your benefits, you may appeal the Plan Administrator's decision.

Benefit Determinations (Claims Decisions)

This section describes ERISA claims procedures in general so that you will understand your rights and responsibilities. You should also consult any specific information about claims procedures that you may receive.

If your claim under the Plan is denied in whole or in part, the following procedures will apply, depending upon the type of claim:

1. Post-Service Claims. Post-Service Claims are those claims that are filed for payment of benefits after dental care has been received. If your Post-Service Claim is denied, you will receive a written notice from the Contract Administrator

within 30 days of receipt of the claim, as long as all necessary information was provided with the claim. If circumstances beyond the control of the Plan require more time for processing your claim, federal law permits one extension of up to 15 days. You will be notified of any extension before the initial 30 days are up. The notice will explain why an extension is necessary and the date a decision is expected.

2. Pre-Service Claims. Pre-Service Claims are those claims that require notification or approval prior to receiving dental care. If your Pre-Service Claim is submitted properly with all necessary information, you will receive written notice of the claim decision from the Contract Administrator within 15 days of receipt of the claim. If you file a Pre-Service Claim improperly, the Contract Administrator will notify you of the improper filing and how to correct it within 5 days after the Pre-Service Claim was received. If circumstances beyond the control of the Plan require more time for processing your claim, federal law permits one extension of up to 15 days. You will be notified of any extension before the initial 15 days are up. The notice will explain why an extension is necessary and the date a decision is expected.
3. Additional Information. In the case of both Pre-and Post-Service Claims, if an extension of the decision period is necessary because additional information is needed to decide your claim, then the notice of extension will specifically describe the required information and you will have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Contract Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.
4. Urgent Care Claims that Require Immediate Action. Urgent Care Claims are those claims that require notification or approval prior to receiving dental care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain. In these situations:
 - you will receive notice of the benefit determination in writing or electronically within 72-hours after the Contract Administrator receives all necessary information, taking into account the seriousness of your condition.
 - notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you file an Urgent Care Claim improperly, the Contract Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim is received. If additional information is needed to process the claim, the Contract Administrator will notify you of the information needed within 24

hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- the Contract Administrator’s receipt of the requested information; or
 - the end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.
5. Concurrent Care Claims. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to Post-Service or Pre-Service timeframes, whichever applies. However, the Contract Administrator must notify you of any reduction or termination of an on-going course of treatment at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.
6. Denial Notice. If your claim is denied in whole or in part, you will receive written notice of:
- the specific reason or reasons for the denial;
 - specific reference to the Plan provisions on which the denial is based;
 - if a Plan Rule or guideline was relied on in making the initial benefit decision, either the specific Plan Rule or a statement that a copy of the rule will be provided to you free upon request;
 - the additional information, if any, needed to approve your claim and an explanation of why such information is necessary;
 - the Plan claims review procedure, including a statement of your right to bring an action under Section 502(a) of ERISA, following an adverse determination appeal;
 - if the initial benefit decision was based on a Plan exclusion or limit (such as medical necessity or experimental treatment), either an explanation of the basis for the determination or a statement that such explanation will be provide to you free upon request; and
 - if the denial concerned an Urgent Care Claim, a description of the expedited appeal process described below at “Urgent Care Claim Appeals that Require Immediate Action.”

How to Appeal a Claim Decision

If you disagree with a claim determination, you can contact the Contract Administrator in writing to formally request an appeal. Your first appeal request must be submitted to the Contract Administrator within 180 days after you receive the claim denial.

Appeal Process

An appropriate, named Plan fiduciary who did not make the initial decision and who is not a subordinate of the individual who made the initial decision will decide the appeal. The review will show no deference to the initial decision. As part of the review, you or your authorized representative may submit issues and comments in writing. You may also request access to copies of documents, records and other information that was submitted, considered or produced by the Contract Administrator in deciding your claim, and know the identity of any medical experts consulted by the Plan in connection with the initial benefit decision. The Plan fiduciary who considers your appeal will take into account all information you submit, regardless of whether it was submitted or considered in the initial decision. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Contract Administrator and the Plan Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process.

Appeals Determinations

1. Pre-Service and Post-Service Claim Appeals. You will be provided written or electronic notification of decision on your appeal as follows within 30 days for the appeal of a **Pre-Service Claim** and within 60 days for the appeal of a **Post-Service Claim**. If the appeal is denied, you will receive a notice providing –
 - the specific reason or reasons for the denial;
 - specific reference to the Plan provisions on which the denial is based;
 - if a Plan Rule or guideline was relied on in making the initial benefit decision, either the specific Plan Rule or a statement that a copy of the rule will be provided to you free upon request;
 - the additional information, if any, needed to approve your claim and an explanation of why such information is necessary;
 - the Plan claims review procedure, including a statement of your right to bring an action under Section 502(a) of ERISA, following an adverse determination on appeal;
 - if the initial benefit decision was based on a Plan exclusion or limit (such as medical necessity or experimental treatment), either an explanation of the basis for the determination or a statement that such explanation will be provide to you free upon request; and

- the following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

Please note that the Contract Administrator’s decision is based only on whether benefits are available under the Plan for the particular treatment or procedure. The determination as to whether the health service is necessary or appropriate for your care is between you and your doctor. The fact that services or supplies are furnished or prescribed by a doctor or other licensed provider does not necessarily mean either that the services and supplies are medically required under the terms of a plan or that the charge for such services or supplies is eligible for coverage.

2. Urgent Care Claim Appeals that Require Immediate Action. Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your physician should call the Contract Administrator as soon as possible. The Contract Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

For Urgent Care Claim appeals, the Contract Administrator has the exclusive right to interpret and administer the provisions of the Plan. The Contract Administrator’s decisions with respect to Urgent Care Claim appeals are conclusive and binding.

Exhausting Administrative Remedies

If your claim is denied on review, then you may bring a civil action in federal or state court. You may not commence such an action, however, until you have exhausted your administrative remedies under the plan.

SUBROGATION AND RIGHT OF REIMBURSEMENT

The purpose of the Plan is to provide retirees dental coverage for qualified dental expenses that are not covered by a third party. If the Plan pays benefits for any claim you incur as the result of negligence, willful misconduct, or other action or omission of a third party, the Plan will be subrogated to all your rights of recovery. Subrogation applies if you have a legal right to payment from an individual or organization because another party was responsible for your illness or injury. You will be required to reimburse the Plan for amounts paid for claims out of any monies recovered from a third party, including, but not limited to, your own insurance company as the result of judgment, settlement, or otherwise. In addition, you will be required to assist the Plan in enforcing these rights and may not negotiate any agreements with a third party or engage in any other conduct that would undermine the subrogation rights of the Plan.

In addition, the Plan is entitled to reimbursement of any claim paid for which you receive compensation from a third party, other than a family member, for dental expenses that have been paid by the Plan. This is true even if the payment you receive is described as payment for non-dental care expenses, for example, attorney's fees and expenses. If you do not provide the Plan with necessary documents, your claim can be denied.

You must notify the Plan Administrator immediately if you begin settlement negotiations with or obtain a judgment against a third party in connection with an accident or injury for which benefits have been paid by the Plan. The Plan may offset any further payments by the amounts it was unable to recover from a third party who made payments in connection with an accident or injury.

COBRA

Under Federal law, certain participants are entitled to continue coverage under the Plan in certain circumstances where coverage might otherwise end. Your eligible dependent(s) may be able to elect COBRA and continue coverage for a limited period of time if your dependent experiences a qualifying event, such as divorce, legal separation, or reaching age 26. If such an event occurs, you or your dependent must contact the third-party administrator **within 30 days** of the occurrence of such event. Once the third-party administrator has been notified, information regarding COBRA rights will be provided. If your dependent is eligible to elect COBRA coverage and wishes to do so, he or she must elect COBRA coverage within 60 days after the later of the date of the termination of coverage or the date the COBRA notice to elect to continue coverage is provided. The cost of COBRA coverage will be 100% of the cost of coverage, plus an additional 2% administration fee. Once COBRA is elected, you and/or your dependent(s) will then have an additional 45 days to make the required initial payment for COBRA coverage. If COBRA continuation coverage is elected, it may continue for up to 36 months. However, COBRA coverage will end earlier than 36 months if your dependent becomes covered under another group dental plan, required premiums are not paid within 45 days of the due date (for the initial premiums) or within 30 days of the due date (for subsequent premiums) or within any applicable grace period, or the Plan is terminated.

You and your dependents also may be able to elect COBRA and continue coverage for a specified period in the unlikely event of Tufts University's bankruptcy. In this case, coverage for you will continue for up to your date of death and, for your dependents, up to 36 months after your date of death. COBRA coverage may end earlier, however, for the reasons described above.

OTHER INFORMATION

The following section contains information provided to you by the Plan Administrator of the Plan to meet the requirements of the Employee Retirement Income Security Act of 1974. All inquiries relating to the following information should be referred directly to the Plan Administrator.

Plan Name: Tufts University Retiree Dental Benefits Plan

Plan Number: 603

Employer Number: 04-2103634

Plan Sponsor: Tufts University
Human Resources Benefits Office
200 Boston Avenue, Suite 1600
Medford, MA 02155
617.627.7000

Plan Administrator: Tufts University
Human Resources Benefits Office
200 Boston Avenue, Suite 1600
Medford, MA 02155
617.627.7000

The administration of the Plan is under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator has the discretion to determine all matters including, but not limited to, eligibility, coverage, cost, and benefits under the Plan, and has the discretion to determine all matters relating to the interpretation and operation of the Plan. Any determination made by the Plan Administrator will be final and binding on all parties, in the absence of clear and convincing evidence that the Plan Administrator acted arbitrarily and capriciously.

Type of Welfare Plan:

The Plan is a group dental plan covering only retirees and their dependents. As such, it is exempt from the provisions of the Patient Protection and Affordable Care Act.

Plan Year:

The Plan's records are kept on a calendar year ending each December 31.

Administration of Plan:

The Plan is directly administered by the Plan Administrator. The Plan Administrator has delegated the day-to-day administration of COBRA elections and enrollment to the following third-party administrator:

EBPA
37 Industrial Drive, Suite E
Exeter NH 03833
Toll free 888.232.3203
Email: premiumcollection@ebpabenefits.com

The Plan Administrator has delegated the day-to-day administration of benefits, claims, and appeals to the following Contract Administrator, as provider of a Plan coverage option:

Delta Dental Plan of Massachusetts
465 Medford Street
Boston, MA 02129

Notwithstanding anything in this booklet to the contrary, the provider of a Plan coverage option has final discretionary authority to determine benefit claims and appeals with respect to participants and dependents covered by that option.

Agent for Service of Legal Process:

The Plan Administrator is the designated agent for service of legal process on the Plan. In addition, if a dispute arises over post retirement dental benefits under the Plan, legal process may be made upon any trustee of the Retiree Dental Benefits Plan.

Limitation of Liability:

With respect to any prepaid or insured coverage option or other part of the Plan, liability for providing benefits resides solely with the insurance carrier or other provider issuing the applicable prepaid contract or insurance policy. Tufts University has no liability for retiree dental insurance benefits due or claimed under any such contract or policy.

Plan Amendment:

Tufts University has established the Plan with the expectation that it will be continued indefinitely, but Tufts University shall not have any obligation whatsoever to maintain the Plan for any given length of time. Tufts University shall at any time, at its discretion, amend or terminate the Plan, in whole or in part, with respect to any or all of its provisions, including but not limited to, participants' and/or beneficiaries' benefits. No vested rights of any nature are provided under the Plan.

QMCSO:

Procedures relating to Qualified Medical Child Support Orders (QMCSOs) can be obtained from the Plan Administrator without charge.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a participant in the Tufts University Retiree Dental Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, all plan documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room at the Employee Benefits and Security Administration;
- Obtain copies of all documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500) and updated summary plan descriptions and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies;
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to make available to each participant a copy of this summary financial report; and
- Continue group dental coverage as described in this document.

In addition to creating rights for Plan participants, ERISA imposes duties upon people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit from the Plan or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this is done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time periods.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Administrator's control.

If you have a claim for benefits that is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a Medical Child Support Order, you may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (EBSA).

PROTECTING THE PRIVACY OF YOUR HEALTH INFORMATION

Under the Privacy and Security Regulations of the Health Insurance Portability and Accountability Act (“HIPAA”), the Plan is a “covered entity” and is subject to the requirements of the Privacy and Security Regulations published by the U.S. Department of Health and Human Services under HIPAA (the “Privacy Rule”), which place limits on how your health information may be used or disclosed. These include limits on how and when Plan information may be shared with University, as the Plan Sponsor and your employer. The following provisions describe how the Plan may use and disclosure your protected health information (“PHI”). These provisions are consistent with HIPAA’s Privacy Rule requirements. HIPAA and its implementing regulations were modified by the Health Information Technology for Economic and Clinical Health Act (“HITECH Act”), the provisions of which are incorporated herein by reference.

1. The Plan cannot use or disclose your PHI other than as permitted or required by this Plan or as permitted or required by the Privacy Rule. However, the Plan may use or disclose your PHI for the following purposes, provided that the Plan does not use or disclose more PHI than is necessary for the intended purpose:
 - (a) The Plan may use or disclose your PHI with your valid Authorization. For this purpose, an Authorization is your permission to use your PHI for a specific purpose or to disclose your PHI, for specific purposes, to another party.
 - (b) The Plan may use or disclosure your PHI without your Authorization for Plan administration purposes, treatment, payment, or health care operations.
 - (i) Payment includes activities by the Plan to determine or fulfill its responsibility to provide coverage and/or benefits to you.

- (ii) Health care operations include activities to manage and operate the Plan, as defined by the Privacy Rule.
 - (c) PHI may be disclosed to another party, known as a “Business Associate,” such as *Delta Dental*, if that other party agrees by contract to limit its use and disclosure of PHI to comply with the provisions of the Privacy Rule.
 - (d) Summary Health Information may be disclosed to the University, as the Plan Sponsor, for the purpose of obtaining premium bids for the Plan or for modifying, amending, or terminating the Plan. “Summary Health Information” is information that summarizes claims expenses and claims history and generally cannot be used to identify any particular *member*.
 - (e) PHI that does not identify any *member* may be disclosed for any purpose.
 - (f) The Plan may disclose to the University information on whether you are participating in the Plan (enrollment/disenrollment information).
2. Before the Plan discloses any PHI to the University, as Plan Sponsor, the University agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan, the Plan has been amended to incorporate the provisions set forth in Section 3 below and that the University agrees to comply with such provisions.
3. (a) The University agrees (i) to abide by the terms of the Plan regarding the permitted and required uses and disclosures of PHI and (ii) to comply with the Privacy Rule regarding the required use and disclosure of PHI.
- (b) The University shall ensure that any agent or subcontractor to whom it provides PHI received from the Plan agrees to abide by the same restrictions and conditions that apply to the University with respect to the PHI.
- (c) The University will not use or disclose PHI for employment-related actions or decisions or in connection with any of its other employee benefits or employee benefit plans, unless authorized by a *member* or otherwise permitted by the Privacy Rule.
- (d) The University will report to the Plan any improper use or disclosure of PHI of which it becomes aware.
- (e) The University will make PHI available to *members* so they may access their PHI and request that their PHI be amended in accordance with the Privacy Rule. Any amendments agreed upon will be incorporated into such PHI maintained by the University.

- (f) The University will make PHI available in order to provide, upon request, an accounting of all disclosures of *members'* PHI for the immediately preceding six years, as provided under the Privacy Rule.
- (g) The University will make available to the United States Department of Health and Human Services all of its practices, books, and records relating to the use and disclosure of PHI received from the Plan.
- (h) If feasible, once the University no longer needs PHI for its intended purpose, the University will return the PHI to the Plan or destroy all copies of the PHI. If such action is not feasible, the University will limit further use and disclosure of PHI to those purposes that make the return or destruction of the information infeasible.
- (i) The University will ensure that the adequate separation between the Plan and the University (*i.e.*, the "firewall"), required by the Privacy Rule, is satisfied.

The University further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The University will report to the Plan any security incident of which it becomes aware.

4. In order to maintain adequate separation between the Plan and the University, as Plan Sponsor and employer, employees in the following positions within the University will be the only employees who will have access to PHI received from the Plan for Plan administration purposes:
 - (a) Employees working in the University's Benefits Office, or any other department involved in administration of the Plan, any Employee who has had Plan administration duties and responsibilities delegated to him/her by the Administrator, and any auditor, attorney or actuary, physician, vocational expert, or any other person or entity appointed to provide professional or administrative services to the Plan or to the Plan Sponsor in connection with the Plan.
 - (b) Such access to and use of PHI by these individuals is restricted to relevant Plan administration functions, including health care payment and operations and providing support for such functions.
 - (c) The University, as Plan Sponsor, shall establish an effective procedure for resolving any issues of noncompliance by any of the employees in the

positions listed above in the event any such employee violates any of the provisions of this section.

The University will ensure that these provisions are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.