Summary Plan Description

Woods Hole Oceanographic Institution

Restated as of January 1, 2015

This document is a Summary Plan Description (SPD) as described by DOL Reg. Section 2520.102-2 through 4. To the extent there is a conflict between this SPD and the terms of the Plan or one of the insurance contracts identified on Schedule A, the terms of the Plan or contracts will control. The Plan Sponsor reserves the right to amend or terminate this SPD at any time without the consent of any employee, dependent, or beneficiary.

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1. GENERAL PLAN INFORMATION

General Plan Information

Woods Hole Oceanographic Institution Health and Welfare Benefit Plan for Active Employees is the name of the Plan.
Woods Hole Oceanographic Institution, Inc. is the Plan Sponsor / Plan Administrator. Woods Hole Oceanographic Institution, Inc. has assigned Plan Number 501.
The Plan is restated as of January 1, 2015.
The Plan Year, and subsequent years, begins on January 1 and ends on December 31.

Plan Administrator and Service of Legal Process Information

The company's name, address, phone number, and identification number are:

Woods Hole Oceanographic Institution
266 Woods Hole Rd, MS 15
Woods Hole, MA 02543
E.I.N.: 04-2105850

Service of legal process in connection with a plan benefit can be served on the Human Resources department of the above referenced company.

Type of Welfare Plan

The Plan is intended to be an "employee welfare benefit plan" within the meaning of ERISA Section 3(1). The Plan provides the benefits identified in Section 3 and on Schedule A.

Type of Administration

While the Plan Administrator administers the Plan generally, Plan administration varies for each insurance benefit. Some insurance benefits furnished under the Plan are administered by the providers/insurers of the applicable benefit contract. Other insurance benefits may be administered by the Plan Sponsor. If you have questions about the Plan or any insurance benefit, you may contact the Plan Administrator or the contact listed for a particular insurance benefit on Schedule A.

COBRA Administration

Benefit Strategies, LLC.
967 Elm Street
Manchester, NH 03101

Amendment of the Plan

The Plan Sponsor reserves the right to amend the provisions of the Plan at any time and to any extent that it may deem advisable. Unless otherwise provided, any such amendment will be effective for all participants, whether or not employed by the company or any other participating employer.

Termination of the Plan

Although the company has established the Plan, neither the company nor any other participating employer has any obligation whatsoever to maintain the Plan for any given length of time. The company may discontinue or terminate the Plan at any time without liability.

2. HOW DO I KNOW IF I AND MY DEPENDENTS ARE ELIGIBLE UNDER THE PLAN?

You are an eligible employee if:

- You work in the United States for the Plan Sponsor or a participating employer; and
- You are an active W-2 employee (regularly scheduled to work 20 or more hours a week); and
- You meet any other eligibility requirements for an insurance benefit, as set forth on Schedule A or in an applicable contract referenced on Schedule A, and

An eligible dependent is:

Is either a U.S. Citizens or legal resident and generally are:

- Your lawfully married spouse, or your common-law spouse if you live in a state that recognizes common law marriages. ;
- Your domestic partner if you and your partner have lived together consecutively for twelve months and you expect to continue living together in a personal relationship where you have shared financial responsibility ;
- Your unmarried children who rely on you for a majority of their financial support and who you claim as dependents on your federal tax return, including:
    - Your biological children,
    - Your legally adopted children,
    - Your stepchildren, or
    - Any other child permanently living with you for whom you are the legal guardian.

You can cover your children as dependents if they:

- Are younger than 26 years of age; or
- Were disabled adults when you began employment with the Plan Sponsor and you enrolled the child when you were first eligible to do so.

For more information on eligible dependents and for access to the required domestic partner affidavit please visit the WHOI HR website: http://www.whoi.edu/HR/page.do?pid=46820

At all times in this document, "dependents" means "eligible dependents."

3. WHAT BENEFITS ARE AVAILABLE TO ME?

Some of the benefits under the Plan may be paid from the employers general assets and employee contributions. Other benefits are fully insured where premium costs are shared by the employer and the employees as determined by the employer in its sole and absolute discretion and communicated in advance to employees. Employee contributions generally are made on a pre tax basis and may change from time to time as determined by the employer

The Plan's ***Non-Contributory*** **Insurance Benefits** provided to you at our expense are:

- Basic Life and Accidental Death and Dismemberment Insurance
- Short Term Disability Coverage
- Long Term Disability Coverage
- Statutory Disability Coverage
- Employee Assistance Program

The Plan's ***Contributory*** **Insurance Benefits**, which require you to pay all or part of the premium for the insurance, are:

- Group Medical
- Group Dental
- Supplemental Life Insurance
- Flexible Spending Account (Healthcare, FSA & Dependent Care FSA)

More information about eligibility and the cost of these benefits can be found in **Schedule A** which can be found at the end of this document.

4. WHAT ARE MY RIGHTS UNDER FEDERAL LAW REGARDING HEALTH INSURANCE?

(a.) Childbirth and hospital stays

Federal law prohibits the restriction of 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.

(b.) Mastectomies

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires group health plans that provide medical 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 of all stages of mastectomy, including lymphedemas.

(c.) Mental Health and Substance Abuse Parity

The Mental Health Parity and Addiction Equity Act (MHPAEA) requires that the annual or lifetime dollar limits on mental health benefits may be no lower than any such dollar limits for medical and surgical benefits.

- Group medical insurance may not apply annual or lifetime limits for mental health or substance use disorders that are lower than those for medical and surgical benefits.
- Group medical insurance may not apply more restrictive financial requirements or treatment limitations to mental health or substance use disorder benefits in any classification than the predominant limitations applied to substantially all of the medical and surgical benefits in any classification.
- The Plan must provide, upon request, information to participants and providers for determining whether mental health or substance abuse treatment is medically necessary and any reasons for a denial of coverage.
- Coverage of mental health and substance abuse benefits by out of network providers must be on par with out of network coverage for medical treatment.

(d.) Choosing Your Doctor

(i.) Primary Care Provider (PCP)

You have the right to choose any PCP who participates in the group medical coverage network and who is available to accept you or your family members. Each family member has the right to choose a different PCP.

(ii.) Pediatrician

For children, you may designate a pediatrician as the primary care provider.

(ii.) OB/GYN

You do not need prior authorization from your group medical coverage or from any other person in order to obtain access to obstetrical or gynecological care from a health care professional in your network.

(e.) College Students and Michelle's Law

Michelle's Law provides continued health and dental insurance benefits under the Plan for dependent children who are covered under the Plan as a student but lose their student status in a post secondary school or college because they take a medically necessary leave of absence from school. If your child is no longer a student because he or she is out of school because of a medically necessary leave of absence, your child may continue to be covered under the Plan for up to one year from the beginning of the leave of absence.

(f.) The Genetic Information Nondiscrimination Act (GINA)

GINA prohibits the Plan from discriminating against individuals on the basis of genetic information in providing any benefits under the Plan. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history.

(g.) Coverage For Children Up To Age of 26

The Affordable Care Act of 2010 requires that the Plan must make dependent coverage available to adult children until they turn 26 regardless if they are married, a dependent or a student.

(h.) Prohibition of Lifetime Dollar Value of Benefits

The Affordable Care Act of 2010 prohibits the Plan from imposing a lifetime limit on the dollar value of benefits.

(i.) Your health Insurance Cannot be Rescinded

The Affordable Care Act of 2010 prohibits the Plan, or any insurer, from rescinding your health insurance coverage under the Plan for misrepresentation.

(j.) Prohibition of Pre Existing Conditions

Effective January 1, 2014 The Affordable Care Act of 2010 prohibits the Plan, or any insurer, from denying any health insurance claim for any person because of pre existing condition.

(k) Prohibition of Restrictions on Annual Limits on Essential Benefits

The Affordable Care Act of 2010 prohibits the Plan, or any insurer, effective January 1, 2014 from placing annual limits on the value of essential health benefits.

(i.) Certificates of Creditable Coverage

Certificates of creditable coverage are written documents provided by the group medical insurer to show the type of health care coverage a person had (e.g., employee only, employee plus family, etc.) and how long the coverage lasted. Under federal law, most group health plans must provide these certificates automatically when a person's coverage terminates. However, if you do not receive a certificate, you have the right to request one. Certificates must be available to both you and your dependents. The primary purpose of the certificates is to show the amount of "Creditable Coverage" that you had because this can reduce or eliminate the length of time that any preexisting condition clause in a new plan otherwise might apply to you. The group medical insurer will automatically give you a certificate after you lose coverage (whether regular coverage or COBRA continuation coverage) and will make reasonable efforts to provide on the certificate

the names of your dependents who were also covered. The group medical insurer will provide automatic certificates for your dependents when it has reason to know that they are no longer covered. The group medical insurer will provide a certificate for you (or your dependents) upon request if you make the request within 24 months after your coverage terminates. The Plan Administrator will provide you with proof of your coverage upon request.

(j.) Active Duty or Military Leave

If you take a military leave of absence, you are entitled to continue your coverage under certain insurance benefits under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Leave less than 31 days. If you are absent from work due to a period of active duty in the military for less than 31 days, your participation in any applicable insurance benefit will not be interrupted, subject to your payment during such period of your regular employee contribution for such coverage.

Leave 31 days or greater. If your absence extends for 31 days or greater, you may continue to maintain your coverage under an applicable insurance benefit for up to 24 months from the date your absence for purpose of performing military service began. The Plan Sponsor may require you to pay up to 102% of the full premium under each selected insurance benefit, which represents the Plan Sponsor's share, your share, plus 2% for administrative costs.

*Notice of election***.** The Plan Administrator may develop reasonable procedures addressing how continuing coverage may be elected, consistent with the terms of the Plan and USERRA. If you think you may be affected by USERRA, contact the Plan Administrator.

Coordination with COBRA. USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available. However, you should contact your Plan Administrator for more information, since a continuation of coverage under COBRA may be available to your spouse or dependent children in certain circumstances.

(k.) Family Medical Leave Act

The Family Medical Leave Act (FMLA) may entitle you, subject to certain eligibility requirements, to take a job-protected leave for your own serious illness, for the birth or adoption of a child, or to care for a spouse, child, or parent who has a serious health condition. If you are the spouse, son, daughter, parent or next of kin for a covered service member, extended FMLA leave may be available to care for that service member. If you take a leave of absence that qualifies under the FMLA, you may continue your participation in the group medical, and possibly other insurance benefits so long as you continue to contribute your share of the cost of coverage during the leave. Your monthly contributions during FMLA leave will be made pursuant to procedures established by the Plan Administrator. If you lose any coverage during any FMLA leave because you did not make the required contributions, you may re-enroll when you return from your leave. Your coverage will start again on the first day after you return to work and pay the required contributions.

5. ARE THERE TIMES OTHER THAN "OPEN ENROLLMENT" WHEN I CAN ENROLL?

(i.) Health Insurance Portability and Accountability Act (HIPAA)

If neither you nor your dependents enroll for medical or dental coverage offered by the Plan Sponsor when you first become eligible to do so, or during the annual enrollment period, 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. A special enrollment opportunity may be available to you if one of the following two situations arises: (a) you initially declined coverage because you had other health care coverage that you have lost through no fault of your own; or (b) since declining coverage when you were eligible to enroll, you have acquired a new dependent (through marriage, or the birth or adoption of a child) and wish to cover that individual. In regards to situation (a) above, at the time you decline coverage, you must give written notice of your decision to decline coverage to the Plan Administrator and that alternative coverage was your reason for the declination. As long as you meet the HIPAA special enrollment requirements, you can enroll yourself and all of your dependents in the medical coverage offered by the Plan Sponsor within 30 days after you lose your alternative coverage, such as in situation (a), or the date of your marriage, or the birth, adoption, or placement for adoption of your child, such as in situation (b).

(ii.) Children's Health Insurance Program of 2009 (CHIP)

You and your dependents may be able to enroll in the Plan Sponsor's health insurance coverage pursuant to a special enrollment right created by CHIP so long as one of the following conditions is met:

- You or your dependent is covered under a Medicaid Plan under title XIX of the Social Security Act or under a State Child Health Plan under Title XXI of the Social Security Act; or
- Your coverage under the Medicaid Plan is terminated as a result of loss of eligibility and your request for coverage under the Plan Sponsor's health plan coverage is made within 60 days or less after the termination; or
- You request to terminate coverage under our health plan coverage no later than 60 days after the date you or your dependent is determined to be eligible for assistance under a Medicaid Plan or State Child Health Plan.

(iii.) Qualified Medical Child Support Orders (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is an order by a court of law for one parent to provide a child or children with health insurance under this Plan. The Plan Sponsor or Plan Administrator will comply with the terms of any QMCSO it receives, and will:

- Promptly notify you and any alternate recipient (as defined in Section 609(a)(2)(C) of ERISA) of the receipt of a QMCSO and advise you regarding the Plan's health insurance procedures for determining whether a medical child support order is a QMCSO; and
- Establish reasonable procedures to determine whether the court order satisfies the QMCSO requirements as set forth under Section 609 of ERISA; and
- Within a reasonable period of time after receipt of the court order, notify you and each alternate recipient of such determination.

6. CAN COVERAGE UNDER THE PLAN CONTINUE IF MY HOURS ARE REDUCED, A JOB IS LOST, MY CHILD TURNS 26, I GET DIVORCED, OR DIE?

What is COBRA?

The right to continuation of group health coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This section generally explains COBRA continuation coverage, when it may become available to you and your dependents, and what you need to do to receive it.

What are qualified events and who can become a qualified beneficiary?

COBRA continuation coverage is triggered by a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under a group health plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for it.

If you are an eligible employee, you will become a qualified beneficiary if you lose your coverage under the 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 eligible employee, you will become a qualified beneficiary if you lose your coverage under the 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 his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because 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 his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage, i.e., 26 years old, under the plan as a "dependent child."

A child who is born or placed for adoption with the covered employee during a period of COBRA continuation coverage will be eligible to become a qualified beneficiary.

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the eligible employee, or the eligible employee becomes entitled to Medicare benefits (under Part A, Part B, or both), the Plan Sponsor will notify the insurance company of the qualifying event.

You Must Give Notice of Some Qualifying Events. For other qualifying events (divorce or legal separation of you and your spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You should send this notice, in writing, describing the qualifying event, to the Plan Administrator.

COBRA Coverage and FMLA Leave. The taking of leave under FMLA does not constitute a qualifying event under COBRA. However, a qualifying event will generally occur if your FMLA leave ends and you do not return to work and you are terminated. Please contact the Plan Administrator for more information on your (and your spouse's or dependent children's) COBRA eligibility during and following FMLA leave.

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 eligible employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

When the qualifying event is the death of the eligible employee, the eligible employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, 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 eligible employee's hours of employment, and the eligible 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 his 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). When the qualifying event is the end of employment or reduction of the eligible employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator in a timely fashion, 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. To obtain the 11-month extension, you (or a covered family member) must notify the Plan Administrator within 18 months of the original qualifying event.

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 eligible employee or former eligible employee dies, becomes entitled to

Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event.

Can COBRA coverage end prematurely?

COBRA continuation coverage may terminate early if:

- The required premium payment is not paid when due;
- You and your dependents, if any, become covered under another group health plan after the date COBRA coverage is elected that does not contain any exclusion or limitation for any of your preexisting conditions;
- You and your dependents, if any, become entitled to Medicare benefits (under Part A, Part B, or both) after the date COBRA coverage is elected;
- All of the Plan Sponsor's group health plans are terminated; or
- Coverage is extended to 29 months due to disability, then a determination is made that the individual is no longer disabled. You are required under federal law to inform the Plan Administrator of any final determination that you or your dependents are no longer disabled within 30 days of such a determination.

Continuation coverage under COBRA is provided subject to your eligibility. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible for coverage.

How can I elect COBRA coverage?

Each qualified beneficiary has 60 days from either (1) the date coverage is lost under the Plan or (2) the date they are notified of their right to elect continuation coverage, whichever is later, to inform the Plan Administrator that he or she wants to elect continuation coverage. Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the eligible employee and the eligible employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the election notice. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date. There is no extension of the election period.

If you or your dependents choose continuation coverage and pay the applicable premium within the time period specified in the qualifying event notice, the Plan Sponsor is required to provide coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated active employees or family members. If the Plan Sponsor changes or ends group health coverage for similarly situated active employees, your coverage will also change or end.

Qualified beneficiaries do not have to show that they are insurable in order to choose continuation coverage. But a qualified beneficiary must have been actually covered by the Plan the day before the qualifying event in order to elect COBRA coverage.

How much does COBRA coverage cost me?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 % of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan

participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150%).

When and how must I pay for COBRA?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage at the time of your election. However, you must make your first payment for continuation coverage within 45 days after the date of your election (This is the date your election notice is postmarked, if mailed) or you could lose coverage.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make your first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. Your first payment for continuation coverage should be sent to the COBRA Administrator identified in Section 1: General Plan Information.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the 1st of every month. Periodic payments for continuation coverage should be sent to the COBRA Administrator identified in Section 1: General Plan Information.

Grace periods for periodic payments

Although periodic payments are due on the 1st of every month, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Keep your Plan Administrator 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.

Notice of Market Place/Exchange

In addition to continuing your health insurance under COBRA, depending upon your household finances, you and your family may be eligible for subsidized health insurance by contacting a health insurance marketplace or exchange created under the Affordable Care Act. This may be less expensive than COBRA coverage. You can obtain more information on this possibility by contacting healthcare.gov or dialing 1-800-318-2596.

7. HOW DO I SUBMIT A CLAIM?

Any claim for benefits by you or your dependents under the Plan and any subsequent appeal must be filed pursuant to the terms of the applicable insurance contract. The claims process described in each insurance contract which provides insurance benefits are incorporated by reference into this Plan. Read the claim process information promptly and carefully when you wish to submit a claim under a particular insurance benefit. Call the Human Resource Department with any questions or if you need help.

If a claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. If you do not receive a response within 90 days, your claim is treated as denied. (This period may be extended to 180 days under certain circumstances.) Within 60 days after denial, if you want to appeal such denial, you or your beneficiary may submit a written request for reconsideration of the application to the insurer who denied the claim.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The entity who denied your claim will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended to 120 days under certain circumstances.) In this response, you will be provided with an explanation of the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Plan Administrator or the insurer to who it has delegated claims decision authority, has the exclusive right to interpret the provisions of the Plan. Decisions of the Plan Administrator and its insurers are final, conclusive and binding. The Plan Administrator has final claims adjudication authority under the Plan.

Attached as Schedule B, you will find a default ERISA claim process in the event the insurance contracts referenced above lack an ERISA compliant claims process.

8. HOW IS THE PLAN ADMINISTERED?

The Plan Administrator

The Plan Administrator has absolute discretion (i) to interpret the terms of the Plan; (ii) to determine factual questions that arise in the course of administering the Plan; (iii) to adopt rules and regulations regarding the administration of the Plan, including enrollment procedures; (iv) to determine the circumstances under which benefits become payable under the Plan; (v) to make determinations of eligibility under the Plan; and (vi) to make any other determinations that the Plan Administrator believes are necessary and advisable for the administration of the Plan. Any interpretation or determination made by the Plan Administrator will be final, conclusive, and binding on all parties. The Plan Administrator may delegate all or any portion of its authority to any person or entity regarding its responsibilities and the services and benefits under the Plan.

Duties of the Plan Administrator

The Plan Administrator (i) administers the Plan in accordance with its terms; (ii) decides disputes which may arise relative to a Plan Participant's rights; (iii) keeps and maintains the Plan documents and all other records pertaining to the Plan; (iv) pays or arranges for the payment of claims; (v) establishes, communicates and implements procedures to determine whether a medical child support order is qualified under ERISA; and (vi) performs all necessary reporting as required by ERISA.

Plan Administrator compensation

The Plan Administrator serves without compensation; however, all expenses for Plan administration, including compensation for hired services, will be paid by the Plan unless paid by the Plan Sponsor.

The Named Fiduciary

The Plan Administrator is a "named fiduciary" with respect to the 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.

Fiduciary duties

A fiduciary must carry out his or her 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.

Examination of records

The Plan Administrator will generally make available to each eligible employee records under the Plan for examination at reasonable times during normal business hours.

Indemnification of the Plan Administrator

The Plan Sponsor agrees to indemnify and to defend to the fullest extent permitted by law any individual or entity serving as the Plan Administrator or as a member of a committee designated as Plan Administrator against all liabilities, damages, costs, expenses, and fees caused by any act or failure to act in connection with the Plan, if such act or failure is in good faith.

9. WHAT ARE MY ERISA RIGHTS?

The Employee Retirement Income Security Act (ERISA)

As an employee or dependent eligible for benefits under the Plan, you are also considered an ERISA Participant under the Plan. ERISA provides that all Plan Participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) available at the Public Disclosure Room of the Employee Benefits Security Administration. You may also obtain copies of the aforementioned documents for which the Plan Administrator may assess a reasonable charge.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- A certificate of creditable coverage, free of charge, when you lose coverage under group medical insurance, when you become eligible to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

If you have a claim denied, you are entitled to receive a copy of the claim file and all electronic emails, communications and other pertinent documents that can assist you in your appeal of a denied claim.

How can I enforce my ERISA rights?

If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in 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 and your claim is frivolous, the court may order you to pay the Plan's costs and fees. Assistance with your questions

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this SPD or the Plan you can also contact the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration: (866) 444-EBSA. You may also visit their website at www.dol.gov/ebsa.

Schedule A

Summary of Welfare Benefits

As of January 1, 2015

Group Medical Feature

Administrator/Carrier	Contract/Group No.
Blue Cross Blue Shield of MA	0028910

II. Group Dental Feature

Administrator/Carrier	Contract/Group No.
Delta Dental of MA	7814

III. Group Life/AD&D Feature

Carrier	Contract/Group No.
CIGNA	FLX960707

IV. Group LTD Feature

Carrier	Contract/Group No.
CIGNA	LK960623

V. Group STD Feature

Administrator/Carrier	Contract/Group No.
CIGNA	SHD 961210

VIII. Employee Assistance Plan Feature

Administrator/Carrier	Contract/Group No.
E4Health	EAP

XI. Flexible Benefits Feature – Healthcare, Limited Purpose & Dependent Care FSA

Administrator	Contract/Group No.
Health Equity, Inc.	FSA

Schedule B: Default ERISA Claims and Appeal Procedure

1. Claims Procedure for Disability Benefits

The following claims procedure will apply specifically to claims made for disability benefits under one or more Plan features. **To the extent that this procedure is inconsistent with the claims procedures contained in the policies, contracts, summary plan descriptions or other written materials for such Plan features, the claims procedures in such other policies, contracts, summary plan descriptions, or other written materials will supersede this procedure as long as such other claims procedures comply with DOL Regulation §2560.503-1.**

Timing of Benefits Determination

If a claim under the Plan feature is denied in whole or in part, you or your beneficiary will receive written notification within a reasonable period of time, but no later than 45 days after the Plan Administrator's receipt of the claim. The Plan Administrator may extend this period for up to 30 additional days provided the Plan Administrator determines that the extension is necessary due to matters beyond the Plan Administrator's control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date by which the Plan Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Plan Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision. The extension notice will explain the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, you must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information. The period from which you are notified of the additional required information to the date you respond is not counted as part of the determination period.

Benefits Determination Notice

A denial notice will include:

- the specific reason(s) for your adverse benefit determination;
- reference to the specific Plan provision on which the determination is based;
- a description of any additional material or information necessary for you to fix your claim and an explanation of why such material or information is necessary;
- a description of the review procedures, including a statement of your right to bring a lawsuit following an adverse benefit determination on review;
- either the specific rule or guideline used in making your benefits determination or a statement that such a rule or guideline was relied upon in making the determination and that a copy of such rule or guideline will be provided free of charge upon request; and

- if the adverse benefit determination is based on a medical judgment, either an explanation of such judgment, or a statement that such explanation will be provided to you free of charge upon request.

Appeal Process

If you disagree with a claim determination, you can contact the Plan Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The subject individual's name and the identification number from the ID card.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

You have 180 days to appeal an adverse benefit determination.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. 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 Plan Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Timing of Appeal Determination

You will be notified of the Plan Administrator's decision upon review within a reasonable period of time, but no later than 45 days after the Plan Administrator receives your appeal request. The 45-day period may be extended for an additional 45-day period if the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time. You will be provided with written notice prior to the expiration of the initial 45-day period. Such notice will state the special circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision.

Appeal Determination Notice

Your review decision on appeal will include the following:

- the specific reason(s) for the adverse determination;
- reference to the specific Plan provision on which the benefit determination is based;
- a statement that you are entitled to receive, without charge, reasonable access to any document (i) relied on in making the determination, (ii) submitted, considered or generated in the course of making the benefit determination, (iii) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (iv) that constitutes a statement of policy or guidance with respect

to the Plan concerning the claim without regard to whether the statement was relied on;

- either the specific rule or guideline used in making your benefits determination or a statement that such a rule or guideline was relied upon in making the determination and that a copy of such rule or guideline will be provided free of charge upon request;

- if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the terms of the Plan to your medical condition, or a statement that such explanation will be provided without charge on request;

- a statement describing the Plan's optional appeals procedures, and your right to receive information about such procedures, as well as your right to bring a lawsuit; 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."

The Plan Administrator has the exclusive right to interpret the provisions of the Plan. Decisions of the Plan Administrator are final, conclusive and binding. The Plan Administrator has final claims adjudication authority under the Plan.

2. Claims Procedures for a Group Health Plan

The following claims procedure will apply specifically to claims made under any group health plan covered under the Plan. **To the extent that this procedure is inconsistent with the claims procedures contained in the policies, contracts, summary plan descriptions or other written materials for a group health plan covered under the Plan, the claims procedures in such other policies, contracts, summary plan descriptions, or other written materials will supersede this procedure as long as such other claims procedures comply with DOL Regulation §2560.503-1 and the Affordable Care Act.**

Benefit Determinations

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice from the Plan Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Plan Administrator will notify you within this 30- day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and hold your claim until all information is received.

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

Pre-Service Claims

Pre-Service Claims are those claims that require notification or approval prior to receiving health care. If your claim is a Pre-Service Claim, and it is submitted improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 5 days. If your Pre-Service Claim is submitted properly with all needed information, you will receive written notice of the claim decision from the Plan Administrator within 15 days of receipt of the claim. The Plan Administrator will notify you within this 15-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and hold your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Plan 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.

Urgent Claims

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

- You will receive notice of the benefit determination in writing or electronically within 72 hours after the Plan 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 Plan 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 Plan 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 Plan Administrator's receipt of the requested information; or

- The end of the 48-hour period within which you were to provide the additional information.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The claims administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved

treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If an ongoing 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.

Benefits Determination Notice

A denial notice for a group health plan will include:

- the specific reason(s) for your adverse benefit determination;
- reference to the specific Plan provision on which the determination is based;
- a description of any additional material or information necessary for you to fix your claim and an explanation of why such material or information is necessary;
- a description of the review procedures, including a statement of your right to bring a lawsuit following an adverse benefit determination on review;
- either the specific rule or guideline used in making your benefits determination or a statement that such a rule or guideline was relied upon in making the determination and that a copy of such rule or guideline will be provided free of charge upon request;
- if the adverse benefit determination is based on a medical judgment, either an explanation of such judgment, or a statement that such explanation will be provided to you free of charge upon request; and
- in the case of an Urgent Care Claim, a description of the expedited review process to which you may be entitled.

In addition to the notice standards described above, to the extent required by the Affordable Care Act, all adverse benefit determination notices will include the following: (a) information identifying the claim involved, including the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code, and the corresponding meaning of those codes; (b) the reason or reasons for the adverse benefit determination that includes the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used to deny the claim (for notices of final internal adverse benefit determinations, the description will include a discussion of the decision); (c) a description of available internal appeals and external review processes, including how to initiate an appeal; and (d) contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist individuals with the internal claims and appeals and external review processes.

How to Appeal a Claim Decision

If you disagree with a claim determination, you can contact the Plan Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of health care service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Plan Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. 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 Plan Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

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

For appeals of Pre-Service Claims, the first level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of Post-Service Claims, the first level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with Urgent Claims, see "Urgent Claim Appeals" below.

If you are not satisfied with the first level appeal decision of the Plan Administrator, you have the right to request a second level appeal from the Plan Administrator. Your second level appeal request must be submitted to the Plan Administrator within 60 days from receipt of first level appeal decision.

Please note that the Plan Administrator's decision is based only on whether or not benefits are available under the group health plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

Urgent Claim Appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your doctor should call the Plan Administrator as soon as possible, and provide the Plan Administrator with the information identified above under "How to Appeal a Claim Decision." The Plan 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.

Appeal Determination Notice

Your review decision on appeal will include:

- the specific reason(s) for the adverse determination;
- reference to the specific Plan provision on which the benefit determination is based;
- a statement that you are entitled to receive, without charge, reasonable access to any document (i) relied on in making the determination, (ii) submitted, considered or generated in the course of making the benefit determination, (iii) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (iv) that constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;
- either the specific rule or guideline used in making your benefits determination or a statement that such a rule or guideline was relied upon in making the determination and that a copy of such rule or guideline will be provided free of charge upon request;
- if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the terms of the Plan to your medical condition, or a statement that such explanation will be provided without charge on request;
- a statement describing the Plan's optional appeals procedures, and your right to receive information about such procedures, as well as your right to bring a lawsuit; 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."

If you file an internal appeal for medical benefits, you will continue to be covered pending the outcome of the internal appeal. This means that the Plan shall not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

Voluntary External Review

If the Group Medical Feature in which you are enrolled is not subject to a State external review process and is not a "grandfathered" plan for purposes of the Affordable Care Act, and your internal appeal of a claim for benefits (not related to employee classifications) under such plan is denied, you will have the right to request an external (i.e., independent) review if you do so within four months after receiving notice of an adverse benefit determination or final internal adverse benefit determination. Within five business days after receiving your request, a preliminary review will be completed to determine whether: (i) you are/were covered under the Plan; (ii) the denial was based on your ineligibility under the terms of the Plan; (iii) you have exhausted the Plan's internal process, if required; and (iv) you provided all information necessary to process the external review. Within one business day after completing the preliminary review, you will be notified in writing if your appeal is not eligible for an external review or if it is incomplete. If your appeal is complete but not eligible, the notice will include the reason(s) for ineligibility. If your appeal is not complete, the notice will describe any information needed to complete the appeal. You will have the remainder of the four month filing period or 48 hours after receiving the notice, whichever is greater, to cure any defect. If eligible for an external review, your appeal will be assigned to an independent review organization (IRO). If the IRO reverses the Plan's denial, the IRO will provide you written notice of its determination.

In addition, you will have the right to an expedited external review in the following situations:

- Following an adverse benefit determination involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal.

- Following a final internal adverse benefit determination involving (i) a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or (ii) an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a facility.

The IRO will provide notice of its final external review decision as expeditiously as your medical condition or circumstances require, but not more than 72 hours after the IRO receives the request.