

# **BRANDEIS UNIVERSITY**

## **BENEFITS AND SERVICES**

### **FOR**

## **FACULTY MEMBERS**

OFFICE OF HUMAN RESOURCES AND EMPLOYEE RELATIONS  
JUNE, 2006

# TABLE OF CONTENTS

<b>Introduction.....</b>	<b>1</b>
Medical Insurance.....	2
Health Comparison Chart .....	7
Dental Insurance.....	8
Summary of HIPAA Privacy Rights.....	11
Continuation of Health and Dental Coverage under COBRA .....	11
Group Term Life Insurance .....	14
Group Long Term Total Disability Insurance .....	16
Basic Retirement Plan .....	17
Flexible Dependent Care Reimbursement Account.....	30
Flexible Health Care Reimbursement Account.....	34
Group Travel Accident Insurance Plan .....	37
Long Term Care Insurance .....	39
Social Security .....	40
Unemployment Compensation.....	40
Worker's Compensation.....	40
Tuition Remission .....	41
Activities and Services .....	46
Summary Plan Descriptions	
Medical Insurance Plan #503.....	49
Dental Insurance Plan #511 .....	52
Group Life Insurance Plan #505 .....	55
Long-Term Disability Plan #508 .....	58
Retirement Plan #001 .....	62
Flex Dependent Care Reimbursement Account Plan #512.....	66
Flex Health Care Reimbursement Account Plan #519.....	69
Travel Accident Insurance Plan #510 .....	72
Educational Assistance Plan #518.....	76

# INTRODUCTION

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The goal of the fringe-benefit program at Brandeis University is to provide faculty with a core set of benefits that will provide them with options to adequately meet their needs and the needs of their families. In addition to these core benefits, the University provides additional benefits, services and activities to help enhance the quality of life.

Since the University's founding in 1948, the benefit program has been developed and changed to respond to the needs of its faculty. Fringe benefits are reviewed annually. Suggestions and recommendations from faculty are encouraged. Changes in benefits are based on need and available resources as well as any governmental regulations that might impact such benefits. The University may eliminate from the provisions set forth herein when, at its discretion, circumstances warrant.

The University currently offers health and dental insurance, life and disability insurance plans, and a retirement program as core benefits to eligible faculty. Information about activities and services such as the child-care program, parking, recreation and athletic privileges, savings bonds program and credit union available to faculty may be found on Page 46. Theater, music, art exhibits, summer school courses, and other activities available throughout the year are publicized throughout the campus. Information about the University's various lecture series is provided to faculty on a regular basis.

Faculty members who have appointments of at least half-time status for one semester or more are eligible to participate in the benefit program unless otherwise stated.

Information relating to sick leave and other leaves of absence for faculty may be found in the Faculty Handbook, copies of which are available from the Dean of Arts and Sciences.

If you elect to enroll in one of the health insurance plans Tufts Health Insurance will send you detailed information regarding the plan you selected. If you elect to enroll in one of the dental insurance plan a subscriber certificate will be sent to you via campus mail. Individual life and long term disability insurance contracts are sent to each participant after enrollment via campus mail. Summary Plan Descriptions may be found at the end of this booklet.

**The contents of this handbook are informational only. The plans, benefits, policies and procedures described herein are not conditions of employment. Brandeis University reserves the right to modify, revoke, suspend, terminate, or change any and all such plans, benefits, policies and procedures at any time, as it deems necessary, with or without notice.**

Additional information and applications for fringe benefit programs are available from:

Office of Human Resources and Employee Relations  
MS 118, Brandeis University  
PO Box 549110  
Waltham, MA 02454-9110

## **MEDICAL INSURANCE**

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The University offers you and your eligible family members a choice between three Tufts Health Plan options. There are no pre-existing condition limitations under these plans. The University offers the following plans:

- Tufts Value HMO Plan
- Tufts Premium HMO Plan
- Tufts PPO Plan

### **HMO Plans**

An HMO plan is a health care plan in which a network of health care providers delivers managed care at a center or as part of a network. Participants are required to choose a primary care physician (PCP) from the plan's network of doctors. Your PCP provides or authorizes most of your care, except in cases of emergency and certain other situations as outlined in your member handbook. You choose a PCP for yourself and for each covered family member to coordinate the care you receive. For more specialized care, your PCP will select and refer you to a Tufts Health Plan network specialist, usually one who practices with your doctor's provider group.

### **PPO Plan**

The Tufts Preferred Provider Organization (PPO) allows participants to manage their own health care. You do not need a primary care physician. The PPO offers two kinds of care under one plan. If you choose a provider within the Tufts network for covered services, all you pay is an office visit co-payment. If you choose a provider outside the Tufts network, you pay a deductible for covered services after which you will be responsible for paying the coinsurance for covered services up to the out-of-pocket maximum.

## **Faculty Residing Beyond the Tufts HMO Service Area**

Faculty who reside outside of Massachusetts and who do not live within the Tufts HMO service area (service area includes some parts of New Hampshire, Rhode Island, Vermont and Connecticut) are not eligible to enroll in the HMO Plans. Your option for health insurance coverage is the Tufts PPO Plan.

## **Summary of Benefits**

Insurance Plan enrollment kits describing the health insurance coverage are available in the Benefits section of the Office of Human Resources and Employee Relations. A brief summary of benefits and co-payments is available on the Human Resources website. The Health Insurance Plan Comparison Chart in this handbook provides a brief overview of covered services that is available under each plan. It is designed to help you select the plan best suited to your needs. Upon enrollment, Tufts HMO participants will receive an "Evidence of Coverage Handbook" and Tufts PPO participants will receive a "Certificate of Insurance Handbook" detailing the provisions of the program, an identification card and other relevant material from the insurance carrier. The Evidence of Coverage Handbook and the Certificate of Insurance Handbook are the legal documents governing all matters pertaining to the health insurance program.

## **Eligibility**

Regular full-time and part-time benefits eligible faculty members are eligible to participate in the health insurance program.

In general, your spouse, qualified same-sex domestic partner (with whom you have filed with the University a domestic partner affidavit) and unmarried children up to age 19 may be enrolled under family membership. Coverage may continue up to age 25 for your unmarried dependent children who are full-time students at an accredited education or vocational institution (see the COBRA section of this handbook regarding option to continue coverage following the termination of dependent status). Permanently physically or mentally disabled children over age 19 may also be covered (dependent verification is required). Refer to your Tufts Evidence of Coverage or Tufts Certificate of Insurance handbooks for more information.

## **Enrollment**

Newly hired faculty members must complete a Tufts Health Plan member enrollment form and submit it to the Benefits section of the Office of Human Resources and Employee Relations within 31 days of their hire date. Member Enrollment Forms are available in the Benefits section of the Office of Human Resources and Employee Relations. After the initial eligibility period has passed, eligible faculty and their eligible dependents may choose to enroll during any subsequent open enrollment period or within 31 days after a qualifying event or other permissible event occurs to the participant (subscriber) or to his or her dependent.

## **Coverage Effective Date**

Coverage begins on the first of the month that coincides with or immediately follows date of hire or date of hire if it coincides with the University's first working day of the month.

## **Change in Status**

### **(Qualifying Events/HIPAA Special Enrollment Periods/Other Permissible Events)**

IRS regulations under Section 125 of the Internal Revenue Code require that once you have made your pre-tax election for coverage, you may not change them during the plan year unless you have a qualifying change in status or other permissible event. If you request an election change, it must be on account of and correspond with the change in status. If you experience a change in status, or other permissible event, you must contact the Benefits section of the Office of Employee Relations within 31 days of the event; otherwise, you will need to wait until the next annual open enrollment. The plan administrator reserves the right to review and interpret all requests for a benefit change due to a change in status or other permissible event.

## **Qualifying Events**

1. Change in legal marital status, including marriage, death of spouse, divorce, legal separation, annulment, commencement or termination of a same-sex domestic partner relationship;
2. The birth, adoption or placement for adoption of a child;
3. Death of a spouse/same-sex domestic partner or dependent;
4. You, your spouse/same-sex domestic partner or eligible dependent has a change in job status that effects eligibility for benefits coverage under the University plan or a plan of your spouse/same-sex domestic partner or eligible dependent's employer;
5. Covered dependent reaches the age limit for coverage making him or her ineligible for coverage;
6. You, your spouse/same-sex domestic partner or eligible dependent moves out of or into your medical plan's service area.
7. You, your spouse/same-sex domestic partner or eligible dependent begins or returns from an unpaid leave of absence.

## **HIPAA Special Enrollment Rights**

### **(Health Insurance Portability and Accountability Act)**

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in the University's health plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself or your dependents in the University's health plan provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. The plan administrator reserves the right to review and interpret all requests for a special enrollment period.

## **Other Permissible Events**

1. You may change your election to either provide health coverage or cancel health coverage for your dependent child under a Qualified Medical Child Support Order (“QMCSO”) if the order stipulates that your plan or the other parent’s plan must cover the dependent child.
2. If you, your spouse or eligible dependent becomes covered by Medicare or Medicaid, you may elect to cancel health coverage offered through the University for that individual.
3. If you, your spouse or eligible dependent is covered by either Medicare or Medicaid and subsequently loses coverage, you may elect health coverage offered through the University for that individual.
4. If a new medical benefit becomes available through the University (or an existing medical benefit is eliminated) during the plan year, or if a similar change occurs under a plan of your spouse/same-sex domestic partner or eligible dependent’s employer, you may elect the new coverage (or may elect another option if a coverage has been eliminated), and may make corresponding election changes regarding similar coverage for the balance of the plan year.
5. If your spouse/same-sex domestic partner or eligible dependent makes an election change under a plan maintained by his or her employer, you may make an election change for the balance of the plan year that is on account of and corresponds with the election change made by your spouse/same-sex domestic partner or eligible dependent, provided that either (a) the election change made by your spouse/same-sex domestic partner or eligible dependent under his or her employer’s plan satisfies the cafeteria plan rules contained in the Internal Revenue Code, or (b) the plan year of the plan maintained by your spouse/same-sex domestic partner or eligible dependent’s employer does not correspond with the University’ calendar year plan year.

## **Effective Date of Change in Status**

Contact the Benefits section of the Office of Human Resources within 31 days of a change in status. Otherwise, you will not be able to make a change in status until the next annual open enrollment period or a subsequent permissible event, whichever occurs sooner. The Plan Administrator reserves the right to review and interpret all requests for a benefit change due to a change in status. The change will be effective the date of the event, i.e., date of birth or marriage.

## **Changing Plans – Open Enrollment**

The opportunity to switch from one plan to another, to join for the first time, or to add dependents without a qualifying event, is available for a two week period each November with an effective date of January 1. The Benefits section of the Office of Human Resources and Employee Relations will announce the open enrollment period each year.

## **Provider Directories/Physician Listings**

Provider directories/physician listings for the applicable medical provider networks utilized by the plans will be furnished as separate documents without charge by the Plan Administrator. If the provider directories/physician listings are provided in electronic form, paper copies will be made available and may be requested from the Benefits section of the Office of Human Resources and Employee Relations free of charge. The provider directory/physician listings can be found at [www.tuftshealthplan.com](http://www.tuftshealthplan.com).

## **Cost**

The University currently contributes to the cost of your health coverage. The amount you contribute depends on the health coverage option you choose and whether you elect individual or family coverage.

Unless otherwise instructed, the contribution amount will be deducted from your salary before taxes are withheld for federal income, state income and FICA tax purposes.

**Exception:** The IRS generally does not recognize same-sex domestic partner relationship as a family unit, and therefore premiums for same-sex domestic partners' medical coverage may not be deducted on a pre-tax basis. As a result, you must pay the full cost of your domestic partner's medical coverage. This cost shall either be deducted from your after-tax compensation and/or, to the extent any of the cost is paid by the University, the University's contributions will be treated as taxable compensation received by you.

## Changes in Cost

The cost of your medical coverage is subject to change from time to time. The rates usually change each January 1.

## The Newborns' and Mothers' Health Protection Act of 1996

Under Federal law, group health plans and health issuers offering health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section. Also, they may not require a provider to obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

## Women's Health and Cancer Rights Legislation

Under the Women's Health and Cancer Rights Act of 1998, health plans that cover mastectomies must also cover reconstructive breast surgery following the mastectomy, including:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearances; and
- Prosthesis and physical complications at all stages of the mastectomy, including lymph edemas.

These procedures will be covered the same as your medical plan covers other eligible expenses. Certain general coverage limitations may apply including, but not limited to, deductibles, co-insurance, co-payments, reasonable and customary charges, approval of your primary care physician, etc. Refer to your Tufts Evidence of Coverage or Tufts Certificate of Insurance handbook.

## Claims Procedures

Under certain circumstances, you may be required to file a claim form to obtain benefits. Any required claim forms are available from Tufts Health Plan.

If you are required to complete a claim form and any benefits under the plan are denied, you have the right to request a full and fair review of your claim. If you believe you are incorrectly denied all or part of your benefits, you may appeal the benefit denial.

Please refer to your Tufts Evidence of Coverage or Tufts Certificate of Insurance handbook for a summary of claim procedures and appeal processes. Information can be found under the Satisfaction Process section of your handbook.

## When Coverage Ends

Coverage for you and your eligible dependent(s) ends on the earliest of the following dates:

- the last day of the month in which you are no longer in an eligible class for group health coverage under the plan,
- the last day of the month in which you are no longer an employee of the University, or
- the date your covered dependent(s) no longer qualify for group health coverage under the plan, or
- the date the plan terminates.

## **Certification of Medical Coverage**

Tufts Health Insurance will provide you and/or your covered dependents, free of charge, with a coverage certificate after your coverage under the University's plan ends. If you elect COBRA continuation coverage, you will also receive a coverage certificate after COBRA coverage ends. Keep a copy of the coverage certificate(s) you receive, as you may need to prove you had prior coverage if you join a new plan sponsored by another employer or enroll in an individual health insurance plan. You and/or your dependents, or someone on your behalf, may also request a coverage certificate within 24 months of the date your University coverage ended. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 month (18 months for late enrollees) after your enrollment date in your new coverage.

### **Continuation of Group Health Plan Coverage**

You may be able to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. Review the COBRA section of this handbook and your Tufts Evidence of Coverage or Tufts Certificate of Insurance handbook on the rules governing your COBRA continuation rights. You may also be eligible to convert your University group health plan to an individual non-group policy within 31 days following your last day of coverage. Contact Tufts Health Plan for more information.

## **Health Insurance Continuation for Certain Faculty Terminating at Age 62**

For those faculty who decide to retire between the ages of 62 and 65 and who have completed 20 years of benefit-eligible service prior to retirement, the University will continue to contribute toward the cost of the health insurance premium. The University's contribution will cease when the retired faculty member attains age 65 and is eligible for Medicare benefits. This benefit may be altered, amended or terminated by the University at any time without notice.

Covered Services	Tufts Value HMO (6)	Tufts Premium HMO	Tufts PPO	
			In-Network Benefit	Out-of-Network (after deductible) (1)
<b>Outpatient Care</b> Routine Physicals Doctor Office Visits	\$15 / visit \$15 / visit	\$10 / visit \$10 / visit	\$15 / visit \$15 / visit	20% coinsurance 20% coinsurance
<b>Hospitalization</b> Room & Board (3) Physician/Surgeon Services	\$250 / admission Covered in full Covered in full	Covered in full Covered in full Covered in full	Covered in full Covered in full Covered in full	20% coinsurance (7) 20% coinsurance
<b>Day Surgery</b>	\$100 / surgery	Covered in full	Covered in full	20% coinsurance
<b>Maternity</b> Prenatal/Postnatal Care Hospitalization	\$15 / visit \$250 / admission	\$10 / visit Covered in full	\$15 / visit Covered in full	20% coinsurance 20% coinsurance
<b>Out of Pocket Maximum</b>	\$1,000 for single (6) \$2,000 for family	None	None	\$1,000 for single (1) \$3,000 for family
<b>Mental Health &amp; Substance Abuse</b> Inpatient – Non-Biological (3) • Mental Health  • Substance Abuse	\$250 / admission, up to 60 days per calendar year (4)  \$250 / admission, up to 30 days per calendar year (4)	Covered in full, up to 60 days per calendar year (4)  Covered in full, up to 30 days per calendar year (4)	Covered in full, up to 60 days per calendar year (4)  Covered in full, up to 30 days per calendar year (4)	20% coinsurance  20% coinsurance
Outpatient – Non-Biological • Mental Health  • Substance Abuse	\$15 / visit, up to 24 visits per calendar year  \$15 / visit, up to \$500 per calendar year	\$10 / visit, up to 24 visits per calendar year  \$10 / visit, up to \$500 per calendar year	\$15 / visit, up to 24 visits per calendar year  \$15 / visit, up to \$500 per calendar year	20% coinsurance  20% coinsurance
<b>Physical Therapy</b> <i>(short-term physical, occupational and speech therapy)</i>	\$15 / visit	\$10 / visit	\$15 / visit	20% coinsurance
<b>Emergency Care (2)(5)</b>	\$75 / visit	\$75 / visit	\$75 / visit	\$75 / visit
<b>Chiropractic Care</b>	None	None	\$15 / visit, up to 12 visits per calendar year	Plan covers 80%, up to 12 visits/ calendar year
<b>Prescription Drugs</b> <i>(up to a 30 day supply)</i>	\$15, Tier I \$25, Tier II \$40, Tier III	\$10, Tier I \$15, Tier II \$30, Tier III	\$10, Tier I \$20, Tier II \$35, Tier III	20% coinsurance
<b>Mail Order Rx Drugs</b> <i>(up to a 90 day supply)</i>	\$30, Tier I \$50, Tier II \$80, Tier III	\$20, Tier I \$30, Tier II \$60, Tier III	\$20, Tier I \$40, Tier II \$70, Tier III	Not Covered

**Note:** The above is intended as a brief overview of covered services only. Please refer to the Evidence of Coverage booklet (HMO's) or the Certificate of Insurance (PPO) for more detailed benefit information.

#### Terms and Conditions

1. All covered Out-of-Network PPO benefits are paid at 80% after satisfying \$200 deductible for single plans and a \$600 deductible for family plans. The PPO out of pocket maximum on out of network services is \$1,000 individual / \$3,000 family per calendar year, which does not include the deductible.
2. Waived if immediately admitted to the hospital. If admitted, Inpatient co-payment would apply on Value HMO.
3. A semi-private room is provided unless a private room is medically necessary.
4. Treatment must be at a designated Tufts Health Plan facility.
5. If you receive outpatient Emergency care at an emergency facility, you or someone acting on your behalf should call your PCP (HMO) or Tufts HP within 48 hours after receiving care. You are encouraged to contact your Primary Care Physician so your PCP can provide or arrange for any follow-up care that you may need.
6. The HMO Value plan includes an out of pocket maximum of \$1,000 for an individual and \$2,000 for a family per calendar year. Only the inpatient co-payment and day surgery co-payment add up to this maximum.
7. If you receive inpatient services which are not provided by a Network Provider, you must pre-register these services. If you do not Pre-register, you will be subject to a Pre-registration Penalty. Please refer to the Certificate of Insurance for additional information.

# DENTAL INSURANCE

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The University offers you and your eligible family members a choice between two dental insurance options:

- DeltaPremier Dental Plan (Indemnity Dental Plan)
- DeltaCare DMO (Dental Maintenance Organization)

## DeltaPremier Dental Plan

DeltaPremier Dental Plan has contractual agreements with more than 95% of the dentists in Massachusetts. Participating dentists have agreed to accept Plan payments, according to Plan schedules, based on a usual and customary charge. DeltaPremier Dental Plan also provides coverage for services received from dentists who don't participate in the DeltaPremier network. However, your out-of-pocket expenses may be more. Delta Dental's payments for services received from non-participating dentists are based on either the dentist's fee or the maximum plan allowance for the non-participating dentists, whichever is lower. If you utilize the services of a non-participating dentist whose fees are higher than the maximum plan allowance, you will be responsible for the difference between Delta Dental's payment and the dentist's total submitted charges. Please refer to your subscriber certificate for more information.

DeltaCare Dental Maintenance Organization (DMO)

Under the DeltaCare DMO, a personal dentist must be chosen from the list of participating dentists. Coverage is provided for services performed by a DeltaCare dentist as well as limited coverage for out-of-network service. It is not necessary to submit claim forms nor are there any deductibles to be met if services are performed by a DeltaCare dentist.

## Summary of Benefits

A brief summary of benefits and co-payments is available in the Benefits section of the Office of Human Resources and Employee Relations and on the Human Resources website. For more detailed information, a Subscriber Certificate for each plan is available on the Office of Human Resources website or you may request a copy, free of charge, by contacting the Benefits section of the Office of Human Resources and Employee Relations. The Subscriber Certificate is a legal document governing matters pertaining to the dental insurance program.

## Eligibility

Regular full-time and benefits eligible part-time faculty members are eligible to participate in the dental insurance, unless otherwise stated.

In general, your spouse, same-sex domestic partner (with whom you have filed with the University a domestic partner affidavit) and unmarried children up to age 19 may be enrolled under family membership. Coverage may continue up to age 25 under DeltaPremier Dental plan and up to age 23 under Delta Care Dental Plan for your unmarried dependent children who are full-time students at an accredited education or vocational institution. (See the COBRA section of this handbook regarding option to continue coverage following the termination of dependent status.) Permanently physically or mentally disabled children over age 19 may also be covered (Dependent verification is required). Refer to your Subscriber Certificate for more information.

## Enrollment

Newly hired faculty members must complete a Delta Dental enrollment form and submit it to the Benefits section of the Office of Human Resources and Employee Relations within 31 days of their hire date. Member Enrollment Forms are available in the Benefits section of the Office of Human Resources and Employee Relations. After the initial eligibility period has passed, eligible faculty and their eligible dependents may

choose to enroll during any subsequent open enrollment period or within 31 days after a qualifying event or other permissible event occurs to the participant (subscriber) or to his or her dependent.

## **Coverage Effective Date**

Coverage begins on the first day of the month that coincides with or immediately follows date of hire.

## **Change in Status (Qualifying Events/Other Permissible Event)**

IRS regulations under Section 125 of the Internal Revenue Code require that once you have made your pre-tax election for coverage, you may not change them during the plan year unless you have a qualifying change in status or other permissible event. If you request an election change, it must be on account of and correspond with the change in status. If you experience a change in status, or other permissible event, you must contact the Benefits section of the Office of Employee Relations within 31 days of the event; otherwise, you will need to wait until the next annual open enrollment. The plan administrator reserves the right to review and interpret all requests for a benefit change due to a change in status or other permissible event.

### **Qualifying Events**

1. Change in legal marital status, including marriage, death of spouse, divorce, legal separation, annulment, commencement or termination of a same-sex domestic partner relationship;
2. The birth, adoption or placement for adoption of a child;
3. Death of a spouse/same-sex domestic partner or dependent;
4. You, your spouse/same-sex domestic partner or eligible dependent has a change in job status that effects eligibility for benefits coverage under the University plan or a plan of your spouse/same-sex domestic partner or eligible dependent's employer;
5. Covered dependent reaches the age limit for coverage making him or her ineligible for coverage;
6. You, your spouse/same-sex domestic partner or eligible dependent begins or returns from an unpaid leave of absence.

### **Other Permissible Events**

1. If a new dental benefit becomes available through the University (or an existing dental benefit is eliminated) during the plan year, or if a similar change occurs under a plan of your spouse/same-sex domestic partner or eligible dependent's employer, you may elect the new coverage (or may elect another option if a coverage has been eliminated), and may make corresponding election changes regarding similar coverage for the balance of the plan year.
2. If your spouse/same-sex domestic partner or eligible dependent makes an election change under a plan maintained by his or her employer, you may make an election change for the balance of the plan year that is on account of and corresponds with the election change made by your spouse/same-sex domestic partner or eligible dependent, provided that either (a) the election change made by your spouse/same-sex domestic partner or eligible dependent under his or her employer's plan satisfies the cafeteria plan rules contained in the Internal Revenue Code, or (b) the plan year of the plan maintained by your spouse/same-sex domestic partner or eligible dependent's employer does not correspond with the University' calendar year plan year.

## **Effective Date of Change in Status**

Contact the Benefits section of the Office of Human Resources within 31 days of a change in status. Otherwise, you will not be able to make a change in status until the next annual open enrollment period or a subsequent permissible event, whichever occurs sooner. The Plan Administrator reserves the right to review and interpret all requests for a benefit change due to a qualifying event. The change will be effective the date of the event, i.e., date of birth or marriage.

# Changing Plans – Open Enrollment

The opportunity to switch from one plan to another, to join for the first time, or to add dependents without a qualifying event, is available for a two week period each November with an effective date of January 1. The Benefits section of the Office of Human Resources and Employee Relations will announce the open enrollment period each year.

## Provider Directories

Provider directories for the applicable dental provider networks utilized by the plans will be furnished as separate documents without charge by the Plan Administrator. If the provider directories are provided in electronic form, paper copies will be made available and may be requested from the Benefits section of the Office of Human Resources and Employee Relations free of charge. The provider directory for the DeltaPremier Plan can be found at [www.deltamass.com](http://www.deltamass.com). The provider directory for the DeltaCare Plan is not available online.

## Cost

The University currently contributes to the cost of your dental insurance. The amount you contribute depends on the dental coverage option you choose and whether you elect individual or family coverage.

Unless otherwise instructed by the employee, the contribution amount will be deducted from your salary before taxes are withheld for federal income, state income and FICA tax purposes.

**Exception:** The IRS generally does not recognize same-sex domestic partner relationship as a family unit, and therefore premiums for domestic partners' medical coverage may not be deducted on a pre-tax basis. As a result, you must pay the full cost of your domestic partner's medical coverage. This cost shall either be deducted from your after-tax compensation and/or, to the extent any of the cost is paid by the University, the University's contributions will be treated as taxable compensation received by you.

## Changes in Cost

The cost of your dental coverage is subject to change from time to time. The rates usually change each January 1.

## Claims Procedures

Participating dentists will submit claims directly to Delta Dental. Claim forms must be completed if a non-participating dentist provides services. The benefit payment for services of a non-participating Massachusetts dentist may be less than the amount paid to a participating dentist. Non-participating dentists are not obliged to accept the usual and customary fee, and the patient may be billed for the difference between the charge and the amount allowed by Delta Dental. Claim forms may be obtained from the Benefits section of the Office of Human Resources and Employee Relations. Please refer to your Subscriber Certificate for a summary of claim procedures.

## When Coverage Ends

Coverage for you and your eligible dependent(s) ends on the earliest of the following dates:

- the last day of the month in which you or your covered dependents are no longer in an eligible class for group dental coverage under the plan,
- the last day of the month in which you are no longer an employee of the University, or
- the date your covered dependent(s) no longer qualify for group health coverage under the plan.
- the date the plan terminates.

## Continuation of Group Dental Plan Coverage

You may be able to continue dental coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. Review the COBRA section of this handbook for more information.

## **SUMMARY OF HIPAA PRIVACY RIGHTS**

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A federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) required group health plans to protect the confidentiality of your private health information. The privacy provisions of HIPAA will apply to the University's Medical and Dental Insurance Plan and the Health Care Reimbursement Account Plan.

The Plans, and the University, as the Plan sponsor of such Plans, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as otherwise permitted or required by applicable law. By law, the Plans will require all of its business associates to also observe HIPAA's privacy rules. In particular, the Plans will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the University.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the applicable Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

The Plans will maintain a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact the Benefits section of the Office of Human Resources and Employee Relations.

## **CONTINUATION OF HEALTH AND DENTAL COVERAGE UNDER COBRA**

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On April 7, 1986, a federal law known as "COBRA" was enacted requiring that most employers sponsoring group health plans offer employees and their families ("qualified beneficiaries") the opportunity to elect and pay for a temporary extension of health and dental coverage (called "continuation coverage") at group rates in certain instances ("qualifying events") where coverage under the University's Plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. Both you and your spouse should take the time to read this notice carefully.

If you are an employee of Brandeis University covered by one of the Group Health, and/or Dental Plans or you are participating in the Flex Health Care Reimbursement Account, you have a right to choose this continuation coverage if you lose your group health or dental coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse/same-sex domestic partner of an employee covered by one of the Brandeis University Group Health or Dental Plans, you have the right to choose continuation coverage for yourself if you lose group health or dental coverage or participation in Flex Health Care Reimbursement Account under Brandeis University for any of the following four reasons:

1. Termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
2. Divorce or legal separation from your spouse;
3. Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
4. The death of your spouse.

A dependent child of an employee covered by a Group Health or Dental Plan has the right to choose continuation coverage if group health or dental coverage under the Group Health or Dental Plans is lost for any of the following five reasons:

1. The dependent ceases to be a "dependent child" under the Group Health or Dental Plans;
2. A parent becomes entitled to Medicare benefits (Part A, Part B, or both);
3. The termination of the parent-employee's employment (for reasons other than gross misconduct) or reduction in parent-employee's hours of employment with Brandeis University;
4. The parents become divorced or legally separated; or
5. The death of the parent-employee.

Under the law, the employee or a family member has the responsibility to inform Brandeis University, Office of Human Resources and Employee Relations, Benefits section, of a divorce or legal separation, or a child losing dependent status under one of the University's Health or Dental Plans within 60 days of the later of the date of such event or the date on which coverage would be lost because of such event. The University requires that you deliver or mail written or electronic notification to the Benefits section of the Office of Human Resources and Employee relations of such event. The University has the responsibility to notify the Plan Administrator of the employee's death, termination of employment, reduction in hours or Medicare entitlement.

Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform the University that you want to elect continuation coverage. If you do not elect continuation coverage on a timely basis, your group health and/or dental coverage will end. If you elect continuation coverage, the University is required to permit you to elect and purchase coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Health and/or Dental Plan to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for 36-months unless you lost group health and/or dental coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months.

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan in writing within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

The 18-months may be extended to 29-months if a qualified beneficiary is determined by the Social Security Administration (for purposes of Title II (OASDI) or Title XVI (SSI) of the Social Security Act) to have been disabled at any time during the first 60 days of COBRA continuation coverage. This 11-month extension is available to all individuals who are qualified beneficiaries due to a termination in employment or reduction in hours. To benefit from this extension, the qualified beneficiary must notify the Plan Administrator in writing of the Social Security Administration's determination within 60 days of such a determination and before the end of the original 18-month period of continuation coverage. The qualified beneficiary must also notify the Plan Administrator in writing within 30 days of the date of any final determination by the Social Security Administration that the individual is no longer disabled. The University requires that you deliver or mail written or electronic notification to the Benefits section of the Office of Human Resources and Employee Relations of such event. Furthermore, the monthly premium cost to such a qualified beneficiary during the 11-month extension will be increased to 150% of the applicable premium relating to continuation coverage.

A child who is born to or placed for adoption with the covered employee during a period of COBRA continuation coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Health and/or Dental Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA continuation coverage upon proper notification to the Plan Administrator of the birth or adoption. The

University requires that you deliver or mail written or electronic notification to the Benefits section of the Office of Human Resources and Employee Relations of such event.

However, this law also provides that your continuation coverage may cut short for any of the following reasons:

1. any required premium is not paid in full on time,
2. a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
3. a covered employee becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
4. The qualified beneficiary extends coverage for up to 29-months due to disability and there has been a final determination that the individual is no longer disabled; or
5. Brandeis University no longer provides group health or dental coverage to any of its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose preexisting condition limitations. These rules are generally effective for plan years beginning after June 30, 1997. HIPAA coordinates COBRA's other coverage cut-off rule in (2) above with these new limits as follows:

If you become covered by another group health and/or dental plan after the date of your COBRA election, and that plan contains a preexisting limitation that affect you, your COBRA coverage cannot be terminated. However, if the other plan's preexisting condition does not apply to you by reason of HIPAA's restrictions on preexisting condition clauses, the University may terminate your COBRA coverage.

Failure to pay any required premium on a timely basis will result in the permanent termination of continuation coverage.

You do not have to show proof of insurability to choose continuation coverage. However, as discussed above, you will have to pay all the required premium for your continuation coverage. Individuals electing continued coverage through Brandeis University will assume 102% of the monthly premium for health and dental insurance coverage as permitted under the law. The law also states that, at the end of the 18-month, 29-month, or 36-month continuation coverage period, you must be allowed to enroll in an individual conversion Health or Dental plan if such an individual conversion Health or Dental Plan is otherwise generally available under the Health or Dental Plan.

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

Please contact the Benefits section of the Office of Human Resources and Employee Relations if you have questions regarding COBRA. Also, contact the Benefits section if you have changed marital status. The University requires that you deliver or mail written or electronic notification to the Benefits section of the Office of Human Resources and Employee Relations of such event.

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members ("qualified beneficiaries"). You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Same-sex domestic partners are not considered qualified beneficiaries under COBRA. However, the University extends rights similar to COBRA to eligible same-sex domestic partners.

# Plan Contact Information

If you would like more information about the Plan and COBRA continuation coverage please contact:

Brandeis University  
Director of Benefits  
Mail Stop 118  
415 South Street  
Waltham, MA 02454  
(781) 736-4468

## LIFE INSURANCE

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### Benefit Overview

The University provides group term life insurance coverage to eligible faculty. The following is a summary of the coverage. The Group Life Insurance certificate describes the insurance in detail. The provisions of the formal plan document and not this summary shall govern entitlement to benefits, benefit levels and all other matters pertaining to the life insurance program.

#### Eligibility

Regular full-time and benefits eligible part-time faculty are eligible to participate in the group term life insurance plan on the first day of the month that coincides with or immediately follows the first day of employment. A life insurance card should be completed and submitted to the Benefits section in order to initiate coverage and keep beneficiary information on file. If no beneficiary is elected, then upon the employee's death, the benefit will be made payable to the employee's estate and be subject to all regular federal and state taxes.

### Basic Coverage

The University will pay the entire cost of this portion of the plan. Maximum of basic non-contributory insurance is \$250,000. Schedule of coverage is as follows:

Age Schedule	Amount of Coverage
Up to Age 70	2 x Annual Salary or \$30,000, whichever is higher
Age 70 to retirement	50% of in-force coverage (basic and supplemental)

### Supplemental Coverage

The plan also provided each eligible person the option to purchase an additional amount of term life insurance in increments of \$20,000, \$50,000, \$100,000, and \$200,000. Medical evidence of insurability is not required for any amounts under \$200,000 at the time of initial eligibility. Application for the \$200,000 level of coverage, as well as other levels of coverage when applied for outside of the period of initial eligibility, is subject to medical evidence of insurability. The employee contribution is based on attained age and will change as the age changes in accordance with the following schedule of **monthly premiums**:

Age Schedule	\$20,000	\$50,000	\$100,000	\$200,000
Under 30	\$1.00	\$2.50	\$5.00	\$10.00
30 - 34	\$1.40	\$3.50	\$7.00	\$14.00
35 - 39	\$2.00	\$5.00	\$10.00	\$20.00
40 - 44	\$2.80	\$7.00	\$14.00	\$28.00
45 - 49	\$4.60	\$11.50	\$23.00	\$46.00

50 - 54	\$7.80	\$19.50	\$39.00	\$78.00
55 - 59	\$12.80	\$32.00	\$64.00	\$128.00
60 - 64	\$20.60	\$51.50	\$103.00	\$206.00
65 - 69	\$34.40	\$86.00	\$172.00	\$344.00

## Supplemental Insurance for Employees 70 and Over

When the employee reaches age 70, the in-force coverage will be reduced by 50% and the rate is calculated according to the new benefit level. Please see the table below for the monthly rates:

<i>Age Schedule</i>	<b>\$10,000</b>	<b>\$25,000</b>	<b>\$50,000</b>	<b>\$100,000</b>
70 - 74	\$28.60	\$71.50	\$143.00	\$286.00
75 and over	\$51.50	\$128.75	\$257.50	\$515.00

The basic non-contributory amount (maximum \$250,000) and additional optional insurance coverage may not exceed a combined maximum of \$450,000.

## Insurance Certificate

You will receive an individual insurance certificate detailing your Group Life Insurance provisions.

## Group Life Insurance Taxation

**Social Security (FICA):** The Omnibus Budget Reconciliation Act of 1987 mandates that premiums paid for an employee's group life insurance coverage in excess of \$50,000 are considered income to the employee and subject to Social Security (FICA) taxes. FICA taxes will be deducted on a per pay period basis for those faculty who have life insurance in excess of \$50,000 and who have not paid the maximum FICA tax for the year.

**Federal and State Taxes:** The premiums paid for an employee's group life insurance coverage in excess of \$50,000 are considered income to the employee, are subject to Federal and State taxation and will appear on an employee's W-2 Form as imputed income for the calendar year.

## Waiver of Premium

If an employee becomes totally disabled while insured and it is before age 70, life insurance continues during the disability for 12 months after cessation of premium payments. If the employee furnishes proof that such disability has been continuous for at least nine months before the end of the twelve-month period, the insurance will continue as long as the employee remains disabled. This is subject to the employee submitting proof of continued disability at such intervals as the insurance company may reasonably require. In the event of death during the insurance continuance period, proof must be furnished to the insurance company, within one year following the date of death that the disability had existed uninterrupted until the date of death.

## Designating Beneficiaries

You may designate any beneficiary you wish under the life insurance coverage except the University. This designation may be changed at any time by contacting the Benefits section of the Office of Human Resources and Employee Relations.

## Termination of Employment

Life insurance expires at the end of the month following your termination of employment. If you cease active work without actually terminating employment, you should inquire at the Office of Human Resources and Employee Relations about the duration of coverage.

# Conversion Privilege

Within the 31 days following the end of the month of your termination of employment, you may convert all or part of your current term life insurance under the Group Policy to an individual whole life policy. This policy will be issued on the basis of your attained age and will not require medical examination. The insurance company must receive your completed application and a check for the full first premium payment within 31 days of your date of termination of insurance.

## GROUP LONG-TERM TOTAL DISABILITY INSURANCE

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### Benefit Overview

The University provides group long-term total disability insurance to eligible faculty. A summary of the insurance is listed below. The Group Long Term Disability Insurance certificate describes the insurance in detail. The provisions of the formal plan document and not this summary shall govern entitlement to benefits, benefit levels and all other matters pertaining to the long-term total disability insurance.

### Eligibility

Faculty members who have full-time appointments are eligible for coverage on the first day of the month that coincides with or immediately follows the date of employment. Part-time faculty are not eligible for this plan.

### Definition of Total Disability

Total disability under this program is the inability of the employee, by reason of sickness or bodily injury, to engage in his or her occupation.

### Benefits Coverage

The plan provides the following benefits, which begin on the first day of the month following six consecutive months of total disability and continue during the disability, except as stated under Termination of Insurance.

Monthly Income Benefit is the amount equal to 60% of the first \$13,333 of monthly base salary, to a \$8,000 monthly maximum. This includes any income benefits payable from Social Security and Workers Compensation. In no event will the Disability Insurance Monthly Income Benefit be less than \$100.00 or 10% of the gross monthly benefit, whichever is greater, even though this amount plus Social Security and Workers Compensation Benefits may bring you total income to more than 60% of salary.

### Insurance Certificate

Following enrollment you will receive an individual insurance certificate summarizing your group long-term total disability insurance.

### Termination of Insurance Coverage

Benefits cease on the first day of the month in which the period of continuous total disability terminates, or if earlier, in accordance with the following schedule:

#### Five Year Benefit Duration

Attained Age	Duration of Benefits
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months

65	24 months
66	21 months
67	18 months
68	15 months
69+	12 months

Membership in the Group Plan also terminates if you cease to be in a class of eligible employees, if your work schedule is reduced to a part-time status or the Group Insurance Policy terminates.

# BASIC RETIREMENT PLAN

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## Benefit Overview

The "Plan" is a defined contribution plan that operates under Section 403(b) of the Internal Revenue Code (IRC) and under ERISA section 404(c). The Plan was established by Brandeis University (the "University") in 1952. The purpose of the Plan is to provide retirement benefits for participating employees. Benefits are provided through:

- **Teachers Insurance and Annuity Association (TIAA)** - TIAA provides a traditional annuity and a variable annuity through its real estate account. You can receive more information about TIAA by writing to: TIAA, 730 Third Avenue, New York, NY 10017. You also can receive information by calling 1-800-842-2733.
- **College Retirement Equities Fund (CREF)** - CREF is TIAA's companion organization, providing variable annuities. You can receive more information about CREF by writing to: CREF, 730 Third Avenue, New York, N.Y. 10017. You also can receive information by calling 1-800 842-2733.
- **Fidelity Investments** - Fidelity Investments provides individual custodial accounts through mutual funds. You can receive more information about Fidelity Funds by writing to Fidelity Investments Tax-Exempt Services Company, 82 Devonshire Street, Boston, MA 02109. You also can receive information by calling 1-800-343-0860.

The University is the administrator of the Plan and has designated the Associate Vice President for Human Resources and Employee Relations to be responsible for plan operation. The plan year begins on January 1 and ends on December 31.

## Eligibility

Eligible employee means all faculty members who are scheduled who are scheduled to work full-time or are benefits eligible part-time (except Post Doctoral Fellows/Research Associates, Visiting Scholars or leased employees) faculty, who have attained age 21 (revised 7/1/05) and who have fulfilled the year of service as described below.

## When do I become eligible to participate in the Plan?

If you are an eligible employee, you may, on a voluntary basis begin participation in this Plan on the first day of the month after you complete one year of benefits eligible service at the University. (See the question, "How are years of service counted?" for information on how years of service are measured.) This service requirement is waived for employees who were employed for at least one year in a half-time or more position at a higher education institution immediately preceding the employee's date of employment at Brandeis (up to three months lapse in time between prior employment and Brandeis employment is allowed). Service with such higher education institution will be treated as service with Brandeis for purposes of the one-year of

service requirement. Your former employer must complete a "Service Credit at Other College or University" form.

## **When am I eligible to participate in the Plan if I am reemployed with the University?**

A former employee who is reemployed by the University will be eligible to participate upon meeting the eligibility requirements stated in the previous question "When do I become eligible to participate in the Plan?" A former employee who satisfied these requirements before termination of employment will be eligible to begin participation immediately after reemployment provided the former employee is an eligible employee.

## **How are years of service counted?**

For purpose of eligibility to participate in the Basic Plan, a year of service is a 12-consecutive-month period during which you complete a minimum of 1,000 hours of service (or 750 hours of service in the case of an employee whose normal work schedule is the academic year and who would normally be scheduled to work 40 hours per week; or 650 hours in the case of an employee whose normal work schedule is the academic year and who would normally be scheduled to work 35 hours per week).

Hours of service will be determined on the basis of actual hours that you are paid or entitled to payment. However, no more than 501 hours of service shall be credited under this paragraph on account of any single continuous period during which you perform no duties.

For purposes of determining your eligibility to participate, the computation period starts with your date of hire or re-hire.

## **How will I be notified?**

The University will notify an eligible employee when he or she has completed the requirements necessary to become a Participant. An eligible employee who complies with the requirements and becomes a Participant is entitled to the benefits and is bound by all the terms, provisions, and conditions of the Plan, including any amendments that, from time to time, may be adopted, and including the terms, provisions and conditions of any Funding Vehicle(s) to which Plan Contributions for the Participant have been applied.

## **What contributions will be made to the Plan for my benefit?**

When you begin participation in the Plan, contributions will be made automatically to the funding vehicles that you have chosen at TIAA-CREF or Fidelity. The contributions are based on a percentage of your base compensation, according to the schedule shown below. University Plan contributions will only be made for Participants who are making the required Participant Plan Contributions. Participant Plan Contributions will be deducted from salary payments or, if elected by the Participant, will be made pursuant to a salary reduction agreement on a tax-deferred basis in accordance with the requirements of Code Section 403(b) and the regulations hereunder. Under the salary reduction agreement, the employee's salary (paid after the agreement is signed) is reduced and the amount of the reduction is applied as premiums to the Funding Vehicles available under this Plan. An election to make the required Participant Plan Contributions may not be retroactively and shall remain in effect until the employee is no longer eligible to participate in the Plan or the Plan is terminated.

Plan Contributions as a Percentage of Compensation

<b>Participant's Attained Age</b>	<b>Employee Contribution</b>	<b>University Contribution</b>
Under Age 50	5%	8%
On September 1 <sup>st</sup> ,	5%	10%

following age 50 and one year of service		
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Compensation for any period means the base salary or wages paid by the University to a Participant during the period excluding, for example overtime, bonuses, and any non-cash remuneration. Compensation taken into account under the Plan cannot exceed the limits of IRC Section 401(a)(17). The limit under Section 401(a)(17) is currently \$160,000, adjusted by the Internal Revenue Service for increases in cost-of-living. (rev. 1/1/2006 to \$220,000)

## How do I enroll in the Plan?

To participate in the Plan, an eligible employee must complete the necessary enrollment form(s) and return them to the University. The University will make all determinations about eligibility and participation. The University will base its determinations on its records and the Plan document on file with the Plan Administrator. An employee who has been notified that he or she is eligible to participate but who fails to return the enrollment forms will be deemed to have waived all of his or her rights under the Plan except the right to enroll at a future date.

### What are my Investment options?

Contributions may be invested in one or more of the following fund sponsors and their funding vehicles that are currently available under this Plan. The following is a sample of funds offered through the Retirement Plan.

Teachers Insurance and Annuity Association (TIAA)	College Retirement Equities Fund (CREF)	Fidelity Investments
TIAA Retirement Annuity <ul style="list-style-type: none"> <li>• Traditional Annuity</li> <li>• Real Estate Account</li> </ul>	CREF Retirement Unit - Annuity <ul style="list-style-type: none"> <li>• Stock Account</li> <li>• Money Market Account</li> <li>• Bond Market Account</li> <li>• Social Choice Account</li> <li>• Global Equities Account</li> <li>• Growth Account</li> <li>• Equity Index Account</li> </ul>	International Funds Growth Funds Growth & Income Funds Asset Allocation Funds Income Funds Money Market Funds

A list of individual funds under each of the above categories is available in the Benefits section of the Office of Human Resources and Employee Relations.

Fidelity Select Portfolios are not available for contributions under the Basic Retirement Plan however they are available under the Voluntary Plan.

The Institution's current selection of fund sponsors and funding vehicles isn't intended to limit future additions or deletions of fund sponsors and funding vehicles. You'll be notified of any additions or deletions.

### Investment Responsibility

Both the Basic Plan and the Voluntary Plan are intended to constitute plans described in Section 404 (c) of ERISA and Department of Labor Regulations Section 2500.404c-1 with respect to contributions invested at the direction of the Participant. No person, including the University, the Administrator, TIAA-CREF, or Fidelity Investments, shall be liable for any loss or breach of fiduciary duty which is the direct and necessary result of investments instructions given by a Participant or Beneficiary.

## How do the retirement contracts work?

- If your fund sponsors are TIAA and CREF:
  - **TIAA Traditional Annuity:** Contributions to the TIAA Traditional Annuity are used to purchase a contractual or guaranteed amount of future retirement benefits for you. Once purchased, the guaranteed benefit of principal plus interest cannot be decreased, but it can be increased by

dividends. Once you begin receiving annuity income, your accumulation will provide an income consisting of the contractual, guaranteed amount plus dividends that are declared each year and which are not guaranteed for the future. Dividends may increase or decrease, but changes in dividends are usually gradual. For a recorded message of the current interest rate for contributions to the TIAA Traditional Annuity, call the Automated Telephone Service (ATS) at 1-800-842-2252. The ATS is available 24 hours a day, seven days a week.

- **CREF and the TIAA Real Estate Account:** You have the flexibility to accumulate retirement benefits in any of the CREF variable annuity accounts approved for use under the Plan, as indicated above, and the TIAA Real Estate Account. Each account has its own investment objective and portfolio of securities. Contributions to a CREF account and the TIAA Real Estate Account are used to buy accumulation units, or shares of participation in an underlying investment portfolio. The value of the Accumulation Units changes each business day. You may also choose to receive annuity income under any of the CREF accounts and the TIAA Real Estate Account. There is no guaranteed baseline income or declared dividends when you receive annuity income from these accounts. Instead, your income is based on the value of the annuity units you own, a value that changes yearly, up or down. For more information on the CREF accounts, you should refer to the CREF prospectus. For more information about the TIAA Real Estate Account, refer to the TIAA Real Estate Account prospectus.

For a recorded message of the latest accumulation unit values for the CREF Accounts and TIAA Real Estate Account, as well as the seven-day yield for the CREF Money Market Account, call the ATS at 1-800-842-2252. The recording is updated each business day.

- If your fund sponsor is Fidelity Investments:

You may purchase an income annuity that will provide you with lifetime income payments. You may choose from a fixed annuity, which guarantees an income payment that will not change, or a variable annuity, which will provide you with an income payment that will be tied to the performance of the “sub-accounts” chosen.

## How do I allocate my contributions?

- If your fund sponsors are TIAA and CREF:

You may allocate contributions among the TIAA Traditional Annuity, the TIAA Real Estate Account, and the CREF Accounts in any whole-number proportion, including full allocation to any Account. You specify the percentage of contributions to be directed to the TIAA Traditional Annuity, the TIAA Real Estate Account, and/or the CREF Accounts on the “Application for TIAA-CREF Retirement Annuity Contracts” when you begin participation. You may change your allocation of future contributions at any time after participation begins by calling the ATS toll free at 1-800-842-2252. When you receive your contracts, you'll also be sent a Personal Identification Number (PIN). The PIN enables you to change your allocation by using the ATS. For more information on allocations, ask for the TIAA-CREF booklet *Guiding Your Retirement Savings*.

- If your fund sponsor is Fidelity Investments:

You may allocate contributions among the Fidelity Funds approved by the Institution in any whole-number proportion, including full allocation to any Fund with the exception of Select Funds. You specify the percentage of contributions to be directed to Fidelity and the Funds chosen on the “Account Application for Fidelity Investments 403(b)(7) Custodial Account” when you begin participation. A minimum investment of \$50 per fund per contribution is required. You may change your allocation of future contributions at any time after participation begins by calling Fidelity Tax-Exempt Services Company at 1-800-343-0860. You may request individual prospectus brochures by calling the toll free number. You may also arrange to receive a Personal Identification Number (PIN).

## May I transfer my accumulations?

- If your fund sponsors are TIAA and CREF:
  - Accumulations may be transferred among the CREF accounts and the TIAA Real Estate Account. Accumulations in the CREF Accounts and TIAA Real Estate Account also may be transferred to the TIAA Traditional Annuity or other approved fund sponsors. Complete transfers may be made at any time. Partial transfers may be made from a CREF Account or the TIAA Real Estate Account to the TIAA Traditional Annuity, among the CREF accounts and the TIAA Real Estate Account, or to another approved fund sponsor at any time as long as at least \$1,000 is transferred each time. In addition, transfers may be made from other approved funds sponsors to TIAA-CREF at any time, subject to the rules of the other fund sponsor. There's no charge for transferring accumulations in the TIAA-CREF system.
  - TIAA Traditional Annuity accumulations may be transferred to any of the CREF accounts and TIAA Real Estate Account or to another approved fund sponsor through the Transfer Payout Annuity (TPA). Transfers will be made in substantially equal annual amounts over a period of 10 years. Transfers made under the TPA contract are subject to the terms of that contract. The minimum transfer from the TIAA Traditional Annuity to a CREF account or the TIAA Real Estate Account is \$10,000 (or the entire accumulation if it totals less than \$10,000). However, if your total TIAA Traditional Annuity accumulation is \$2,000 or less, you can transfer your entire TIAA Traditional Annuity accumulation in a single sum to any of the CREF accounts or the TIAA Real Estate Account or another approved fund sponsor, as long as you do not have an existing TIAA TPA contract in force.
  - You may complete transfers within the TIAA-CREF system either by phone or in writing. CREF and TIAA Real Estate Account transfers, as well as premium allocation changes, will be effective as of the close of the New York Stock Exchange (usually 4:00 p.m. Eastern time) on the day the instructions are received by TIAA-CREF, unless you choose the last day of the current month or any future month. Instructions received after the close of the New York Stock Exchange are effective as of the close of the Stock Exchange on the next business day. The toll-free number to reach the ATS is 1 800 842-2252.
- If your fund sponsor is Fidelity Investments:
  - Accumulations may be transferred among Fidelity Funds at any time. There is no charge for transferring accumulations in the Fidelity system. In addition, transfers may be made from other approved funds sponsors to Fidelity at any time, subject to the rules of the other fund sponsor.
  - You may complete transfers within Fidelity by calling Fidelity Investments Tax-Exempt Services Company, 1-800-343-0860.

## How often may I change my future funding options among TIAA-CREF and Fidelity?

You may elect to make a choice of future funding options to manage future retirement contributions four times per year, on January 1, April 1, July 1 and October 1.

## Is there a limit on contributions?

Yes. The total amount of contributions made on your behalf for any year is limited by various federal rules. Some limits apply to the dollar amount that may be contributed; others seek to ensure that higher-paid employees are not benefiting from the Plan in disproportion to lower-paid employees. In some cases,

contributions may be returned to you, for which you will be subject to current income taxation. You will be notified if you are affected by any such limits.

## **Do contributions continue during a leave of absence?**

During a paid leave of absence, Plan contributions will continue to be made based on your base compensation paid during your leave of absence. No contributions will be made during an unpaid leave of absence.

## **Do contributions continue if I become disabled?**

Contributions will be made to the Basic Plan on your behalf if you receive benefits under the Brandeis University Long Term Disability Plan until the earliest of the following events:

- the termination of your disability;
- your death;
- the date on which you begin to receive benefits under the Basic Plan; or
- the date on which you cease to receive benefits under the University's Long Term Disability Plan.

The amount of such contributions shall be based on your base compensation immediately before you became disabled.

## **Do contributions continue while I'm on active duty in the Armed Forces?**

Notwithstanding anything contained in this Plan to the contrary, contributions, benefits, and service credit with respect to qualified military service will be provided in accordance with Section 414(u) of the Code.

## **When do my plan contributions become vested (i.e., owned by me)?**

Plan Contributions shall be fully vested and non-forfeitable when such Plan Contributions are made.

## **What information do I regularly receive about my contracts?**

- If your fund sponsors are TIAA and CREF:

Each year, you will receive an annual Annuity Benefits Report from TIAA-CREF that shows the total accumulation value at year-end for your contracts. This is the amount of death benefits your spouse or other beneficiary would have received on that date. It also includes an illustration of the annuity income you would receive at retirement under certain stated assumptions as to future premiums, your retirement age, the income option and payment method selected, TIAA Traditional Annuity dividends, and the investment experience of the TIAA Real Estate Account and the CREF accounts. These factors affect the amount of your retirement income.

TIAA-CREF also sends you a Quarterly Confirmation of Transactions. This report shows the accumulation totals, a summary transactions made during the period, TIAA interest credited, and the number and value of TIAA Real Estate Account and CREF account accumulation units. You also may receive Premium Adjustment Notices. These notices summarize any adjustments made to your annuities and are sent at the time the adjustments are processed.

And once a year, you'll receive the TIAA-CREF Annual Report. The Annual Report summarizes the year's activity, including details on TIAA and CREF investments, earnings, and investment performance.

- If your fund sponsor is Fidelity Investments:

Fidelity Investments sends you a quarterly statement showing activity during the period, summary of contributions, summary of market values, and transaction history

## **When does my participation terminate?**

A Participant will continue to be eligible for the Plan until one of the following conditions occur:

- You cease to be an eligible employee
- The plan is terminated

## **When does my retirement income begin?**

Retirement income usually begins at retirement. Retirement benefits must normally begin no later than April 1 of the calendar year following the year in which you attain age 70 ½ or retire, whichever is later. Failure to begin annuity income by the required beginning date may subject you to a substantial federal tax penalty.

However, you may begin to receive distributions from your account after age 60 if you participate in an early or phased retirement program or arrangement.

If you die before the distribution of benefits has begun, your entire interest must normally be distributed by December 31 of the fifth calendar year after your death. Under a special rule, death benefits may be payable over the life or life expectancy of a designated beneficiary if the distribution of benefits begins not later than December 31 of the calendar year immediately following the calendar year of your death. If the designated beneficiary is your spouse, the commencement of benefits may be deferred until December 31 of the calendar year that you would have attained age 70 1/2 had you continued to live.

The payment of benefits according to the applicable rules is extremely important. Federal tax law imposes a 50 percent excise tax on the difference between the amount of benefits required by law to be distributed and the amount actually distributed if it is less than the required minimum amount.

Your fund sponsor will normally contact you several months before the date you scheduled your benefits to begin on your application. You may decide, however, to begin receiving income sooner, in which case you should notify the fund sponsor in advance of that date. Usually, the later you begin to receive payments, the larger each payment will be.

### **What options are available for receiving retirement income?**

You have the right to choose an income option will be subject to your spouse's right (under federal pension law) to survivor benefits as discussed in the next question, unless this right is waived by you and your spouse.

The following income options are available:

If your fund sponsors are TIAA and CREF:

#### **Lifetime Retirement Income-**

- One-life annuity. This option provides income for as long as you live. At your death, payments can continue to your designated beneficiaries if you include a guaranteed period. A one-life annuity provides you with a larger monthly income than other options.
- Two-life annuity. This option pays lifetime income to you and an annuity partner (spouse or any other person you name) for as long as either of you live. At the death of both you and your annuity partner, payments can continue to your designated beneficiaries if you include a guaranteed period. The amount continuing to the survivor depends on which of the following three options you choose:

- *Two-thirds Benefit to Survivor.* At the death of either you or your annuity partner, the payments are reduced to two-thirds the amount that would have been paid if both had lived, and are continued to the survivor for life.
  - *Full Benefit to Survivor.* The full income continues as long as either you or your annuity partner is living.
  - *Half Benefit to Second Annuitant.* The full income continues as long as you live. If your annuity partner survives you, he or she receives, for life, one-half the income you would have received if you had lived. If your annuity partner dies before you, the full income continues to you for life.
- One-life or two-life annuity with a guaranteed period. A guaranteed period of either 10, 15, or 20 years can be added to your lifetime annuity income option as long as it does not exceed your life expectancy. Guaranteed periods ensure that benefits continue to your beneficiaries if you and your annuity partner (if applicable) die before the end of the guaranteed period.

**Systematic withdrawals-** This option can provide you the flexibility to determine the amount you'd like to withdraw semimonthly, monthly, quarterly, semiannually or annually (minimum of \$100). You can increase, decrease or suspend the payments at anytime. Systematic cash withdrawals are not available from TIAA Traditional Retirement Annuity.

**Lump Sum-** This represents a single withdrawal of all or a portion of your available TIAA-CREF retirement account. Subject to plan rules, Retirement Annuities only allow cash withdrawals from the CREF variable annuity accounts, the TIAA Real Estate Account and mutual funds. Supplemental Retirement are entirely cashable after you satisfy a triggering event (such as separation from service or attainment of age 59 1/2).

**Small Sum Distribution-** Upon separating from service you may be eligible to withdraw your total Retirement Annuity if the value of your TIAA Traditional does not exceed \$2000 and the total of your accounts is below a certain level as defined by your employer's plan. Therefore, regardless of your age and your employer's cash rules, you may be able to withdraw your retirement account in full; assuming the total accumulation is below the maximum limit set by your Employer's plan (generally \$4,000).

**TPA to Cash-** You can withdraw your Retirement Annuity TIAA Traditional accumulation through the Transfer Payout Annuity (TPA) in 10 approximately equal annual payments.

**Interest-Only-** This option provides monthly payments of the total current interest earned on your TIAA Traditional in Retirement Annuity contracts. Your principal remains intact while you receive the payments. Interest-Only payments are generally available to individuals between ages 55 and 69 1/2.

**The Retirement Transition Benefit-** This option allows you to receive a cash withdrawal of up to 10% of the accumulation converted to lifetime annuity income. The amount you receive as a cash withdrawal will reduce your lifetime annuity income by the same percentage.

**Fixed-Period Annuities-** These options provide income for a specific number of years, not to exceed your life expectancy. At the end of the period, you will have received all of your principal and earnings, and payments stop. Depending on the retirement product, you can select a fixed period from 2 - 30 years.

**Minimum Distribution Option-** Generally, you must begin taking minimum withdrawals from your retirement plans by April 1 following the year you reach age 70 ½ or retire, whichever is later. The Minimum Distribution Option is designed to maximize the tax deferral of your assets while keeping you in compliance with the federal regulations.

**Single Sum Death Benefit-** This is the amount paid to your beneficiary(ies) as a death benefit from your retirement account.

If your fund sponsor is Fidelity Investments:

**A single sum payment**, whereby the entire value or a partial settlement of the Fidelity account is distributed in the form of cash, Fidelity fund shares, or into an IRA Rollover account (IRA - 50% or more of an account).

**A series of installment payments**, which allows a participant to receive withdrawals from the account on a periodic basis - monthly, quarterly, or annually.

**An annuity contract option**, which gives a participant the opportunity to designate his/her own annuity carrier.

**Minimum Distribution Option**- Generally, you must begin taking minimum withdrawals from your retirement plans by April 1 following the year you reach age 70 ½ or retire, whichever is later. The Minimum Distribution Option is designed to maximize the tax deferral of your assets while keeping you in compliance with the federal regulations.

## **What are my spouse's rights under this plan to survivor benefits?**

If you are married and benefits commenced before your death, your surviving spouse will continue to receive income that is at least half of the annuity income payable during the joint lives of you and your spouse (joint and survivor annuity). If you die before annuity income begins, your surviving spouse will receive a benefit that is at least half of the full current value of your annuity accumulation, payable in a single sum or under one of the income options offered by the fund sponsor (pre-retirement survivor annuity).

If you are married, benefits must be paid to you as described above, unless your written waiver of the benefits and your spouse's written consent to the waiver is filed with the fund sponsor on a form approved by the fund sponsor.

A waiver of the joint and survivor annuity may be made only during the 90 day period before the commencement of benefits. The waiver also may be revoked during the same period. It may not be revoked after annuity income begins.

The period during which you may elect to waive the pre-retirement survivor benefit begins on the first day of the plan year in which you attain age 35. The period continues until the earlier of your death or the date you start receiving annuity income. If you die before attaining age 35—that is, before you've had the option to make a waiver—at least half of the full current value of the annuity accumulation is payable automatically to your surviving spouse in a single sum, or under one of the income options offered by the fund sponsor. If you terminate employment before age 35, the period for waiving the pre-retirement survivor benefit begins no later than the date of termination. The waiver also may be revoked during the same period.

All spousal consents must be in writing and either notarized or witnessed by a plan representative and contain an acknowledgment by your spouse as to the effect of the consent. All such consents shall be irrevocable. A spousal consent is not required if you can establish to the institution's satisfaction that you have no spouse or that he or she cannot be located. Unless a Qualified Domestic Relations Order (QDRO), as defined in IRC Section 414(p), requires otherwise, your spouse's consent shall not be required if you are legally separated or you have been abandoned (within the meaning of local law) and you have a court order to such effect.

The spousal consent must specifically designate the beneficiary or otherwise expressly permit designation of the beneficiary by you without any further consent by your spouse. If a designated beneficiary dies, unless the express right to designate a new one has been consented to, a new consent is necessary. A consent to an alternative form of benefit must either specify a specific form or expressly permit designation by you without further consent.

A consent is only valid so long as your spouse at the time of your death, or earlier benefit commencement, is the same person as the one who signed the consent.

If a QDRO establishes the rights of another person to your benefits under this Plan, then payments will be made according to that order. A QDRO may preempt the usual requirements that your spouse be considered your primary beneficiary for a portion of the accumulation.

## **May I begin my retirement income at different times?**

- If your fund sponsors are TIAA and CREF:

Yes. Once you decide to receive your benefits as income, you have the flexibility to begin income from the TIAA Traditional Annuity, the TIAA Real Estate Account, and CREF accounts on different dates. You may begin income from each CREF account and the TIAA Real Estate Account on more than one date provided you begin income from at least \$10,000 of accumulation in that account.

- If your fund sponsor is Fidelity Investments:

Yes. Once you decide to receive your benefits as income, you have the flexibility to begin income from your Fidelity Funds on different dates.

## **May I receive my retirement accumulations under different income options?**

- If your fund sponsors are TIAA and CREF:

Yes, under current administrative practice, you can elect to receive income from your TIAA and CREF annuities under more than one income option to meet your specific retirement needs. However, you must begin income from at least \$10,000 of accumulation under each option.

- If our fund sponsor is Fidelity Investments:

Yes, under current administrative practice, you can elect to receive income from your Fidelity Investments under more than one income option to meet your specific retirement needs. Income options available are described in the distribution guide, "Retiring or Leaving Your Employer", provided by Fidelity.

## **May I receive a cash withdrawal from the Plan after termination of employment?**

- If your fund sponsors are TIAA and CREF:

- Yes, subject to the rights of your spouse to survivor benefits, you may receive all of your CREF and TIAA Real Estate Account accumulations as a cash withdrawal after you terminate employment. TIAA Traditional Annuity accumulations may be received only through the Transfer Payout Annuity (TPA), in substantially equal annual payments over a period of 10 years after you terminate employment. Payments made under the TPA are subject to the terms of that contract.
- You can elect to receive your cash withdrawal of CREF and TIAA Real Estate Account accumulations through a series of systematic payments using TIAA-CREF's Systematic Withdrawal service. This service allows you to specify the amount and frequency of payments. Currently, the initial amount must be at least \$100 per account. Once payments begin, they will continue for the period you specify. You can change the amount and frequency of payments, as well as stop and restart payments as your needs dictate. There is no charge for this service.

- If your fund sponsor is Fidelity Investments:

Yes, subject to your spouse's rights to survivor benefits, you may elect partial or a full withdrawal of your account after you terminate employment.

If I only have a small accumulation in my TIAA-CREF contracts after termination of employment, may I "repurchase" my accumulation and receive it in a single sum?

Yes, subject to your spouse's rights to survivor benefits, you may "repurchase" your TIAA-CREF Retirement Annuities (RAs) in a single sum provided you have terminated employment. In addition, all of the following conditions must apply at the time you request a repurchase:

- If your oldest TIAA or CREF RA was issued on or after January 1, 1992:
  - The total TIAA Traditional Annuity accumulation in *all* your RAs (including contributions to RAs under plans of other employers) is \$2,000 or less.
  - You don't have a TIAA Transfer Payout Annuity (TPA).
- If your oldest TIAA or CREF RA was issued by December 31, 1991:
  - The conditions specified in (a) above are met, or
  - Annuity income hasn't begun, and all the following conditions are met:
    - The total value of your TIAA and CREF RAs is \$2,000 or less, or your oldest TIAA or CREF RA contract is not more than five years old.
    - You're neither employed by nor moving to an institution having a TIAA-CREF funded retirement plan in which you'll be eligible to participate. Employment includes sabbaticals or other leaves of absence. Amounts paid to you upon repurchase will be in full satisfaction of your rights and your spouse's rights to retirement or survivor benefits from TIAA-CREF on such amounts.

Also, as explained earlier, you may elect to receive a cash withdrawal of your CREF and TIAA Real Estate Account accumulations when you terminate employment from the Institution.

## **May I receive a cash withdrawal from the Plan while still employed?**

Yes, if you participate in an early or phased retirement program or arrangement sponsored by the University at age 60, and are age 60 and older, and subject to your spouse's rights to survivor benefits and to the extent provided in an annuity contract or custodial account, you may receive a cash withdrawal of up to 99% attributable to Institution contributions made while employed by the University. However, except for the requirement that you terminate employment, all other conditions described in the question "May I receive a cash withdrawal from the Plan after termination of employment?" will apply.

## **May I receive a cash withdrawal while still employed if I incur a hardship?**

Yes. If you incur a hardship before you terminate employment, you may receive a lump-sum cash payment of accumulations attributable to your own pre-1989 contributions, subject to the restrictions of the funding vehicle.

Hardship distributions of accumulations attributable to your own contributions will be permitted only if you incur an immediate and heavy financial need and the distribution is necessary to meet the financial need. To be considered for a hardship distribution, you'll need to complete an application form and supply supporting

documentation required by the Plan administrator. No earnings attributable to your own contributions credited on or after January 1, 1989 will be available for hardship distributions.

If a hardship distribution of accumulations attributable to your own contributions is made to you, all your employee contributions to any plan maintained by the University will be suspended for 6 months after you receive the distribution. In addition to any other limits under this Plan, your maximum permitted contribution in the next taxable year after the taxable year of the hardship distribution may be reduced by the amount of the hardship distribution. As with any withdrawal, you should consult with your tax advisor since there are possible tax consequences.

## **May I rollover my accumulations?**

If you're entitled to receive a distribution from your contract that is an eligible "rollover distribution," you may rollover all or a portion of it either directly or within 60 days after receipt into another retirement plan or into an IRA. An eligible rollover distribution, in general, is any cash distribution other than an annuity payment, a minimum distribution payment or a payment which is part of a fixed period payment over ten or more years. The distribution will be subject to a 20 percent federal withholding tax unless it's rolled over directly into another retirement plan or into an IRA, this process is called a "direct" rollover.

If you have the distribution paid to you, then 20 percent of the distribution must be withheld even if you intend to roll over the money into another retirement plan or into an IRA within 60 days. To avoid withholding, instruct the fund sponsor to directly roll over the money for you.

## **What if I die before starting to receive benefits?**

- If your fund sponsors are TIAA and CREF:
  - If you die before beginning retirement benefits, the full current value of your annuity accumulation is payable as a death benefit. You may choose one or more of the options listed in your annuity contracts for payment of the death benefit, or you may leave the choice to your beneficiary. The payment options include:
    - Income for the lifetime of the beneficiary with payments ceasing at his or her death.
    - Income for the lifetime of the beneficiary, with a minimum period of payments of either 10, 15, or 20 years, as selected.
    - Income for a fixed period of not less than two nor more than 30 years for CREF accumulations and TIAA Real Estate Account accumulations, as elected, but not longer than the life expectancy of the beneficiary;
    - A single sum payment.
    - A minimum distribution option. This option pays the required federal minimum distribution each year.
  - The accumulation may be left on deposit, for up to one year, for later payment under any of the options.
  - Federal tax law puts limitations on when and how beneficiaries receive their death benefits. TIAA-CREF will notify your beneficiary of the applicable requirements at the time he or she applies for benefits.
  - You should review your beneficiary designation periodically to make sure the person you want to receive the benefits is properly designated. You may change your beneficiary by completing the "Designation of Beneficiary" form available from TIAA-CREF. If you die without having named a beneficiary and you are married at the time of your death, your spouse will automatically receive half of your accumulation. Your estate will receive the other half. If you're not married, your estate receives the entire accumulation.

- In addition, see the answer to the question "What are my spouse's rights under this plan to survivor benefits?" for a discussion of your spouse's rights to a survivor benefit if you are married at the time of your death.
- If your fund sponsor is Fidelity Investments:
  - If you die before your entire interest is distributed to you, the entire remaining interest will be distributed as follows:
    - If the participant dies on or after the participant's beginning date, distribution must continue to be made at least as rapidly as under the method of distribution being used before the participant's death.
    - If the participant dies before the participant's beginning date, the entire remaining interest will, at the election of the beneficiary or beneficiaries, either
      - (A) be distributed by the December 31 of the year containing the fifth anniversary of the participant's death, or
      - (B) be distributed in equal or substantially equal payments over the life or life expectancy of the designated beneficiary or beneficiaries.

The election of either (A) or (B) must be made by December 31 of the year following the year of the participant's death. If the beneficiary or beneficiaries do not elect either of the distribution options described in (A) or (B), distributions will be made in accordance with (A) if the beneficiary or beneficiaries are or include anyone other than the surviving spouse. In the case of distributions under (B), distributions must commence by December 31 of the year following the year of the participant's death. If the participant's spouse is the beneficiary, distributions need not commence until December 31 of the year the participant would have attained age 70 ½, if later.

## **FLEXIBLE DEPENDENT CARE REIMBURSEMENT ACCOUNT**

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### **Benefit Overview**

A Flexible Dependent Care Reimbursement Account allows you to set aside a portion of your salary for dependent care expenses on a pre-tax basis (meaning the federal, state and social security taxes will not be taken). The portion of salary elected is placed into a dependent care expense account and is reimbursed to you as you incur expenses from the date of enrollment through the end of the plan year (Plan year runs from January 1<sup>st</sup> through December 31<sup>st</sup>). The amount you elect to set aside will be deducted in equal amounts from your paychecks.

### **Flexible Dependent Care Reimbursement Account**

The account may be used to pay for dependent care expenses that enable you (and your spouse, if applicable) to work or to search actively for work. You can also use the account to pay for eligible dependent care expenses if your spouse is a full-time student. ("Saturday night" baby-sitting expenses do not qualify). Before you decide to enroll, you may want to compare the Flexible Dependent Care Reimbursement Account to the federal tax credit. You cannot take a federal tax deduction or credit on your income taxes for expenses reimbursed through the Flexible Dependent Care Reimbursement Account. Consult a tax advisor if you have any questions about your individual situation. It is your responsibility to comply with IRS regulations.

## Eligible Dependents

- Your Children under age 13 and for whom the taxpayer is entitled to a dependent deduction under the Internal Revenue Code;
- your spouse, if they are physically or mentally incapable of self-care; and
- Any other person considered a dependent for tax purposes who is physically or mentally incapable of caring for himself or herself.

## Eligible Dependent Care Expenses

The following is a partial list of expenses that may be eligible for reimbursement through the Flexible Dependent Care Reimbursement Account:

- Payment made for services provided in your home as long as services are not provided by someone you also claim as a dependent, nor by your child who is under age 19.
- Payments made for dependent child (child younger than age 13) care services outside your home. If you use the services of a dependent care center that provides care for at least six people (other than residents), the center must be in compliance with state and local laws.
- Expenses for summer day camp programs are allowable but only when the primary purpose of the camp is care; however, if camp hours exceed the employee's working hours, submit only that portion of expense incurred for work-related hours. **Overnight camp is NOT an allowable expense, even on a prorated basis.**
- Payments made for care outside your home for a spouse or for dependents of any age who are mentally or physically disabled and that person must spend at least eight hours a day in your home (this restriction does not apply to dependents under the age of 13).

For more information about eligible and ineligible dependent care expenses, refer to IRS Publication 503, Child and Dependent Care Expenses, available from the IRS or through the IRS Web site at [www.irs.ustreas.gov](http://www.irs.ustreas.gov).

## Contribution Limits

The maximum dependent care deposit, established by the IRS, is the least of the following:

- Actual costs;
- The earned income of the lower paid spouse;
- \$5,000 (\$2,500 if you are married and file separate federal tax returns). The \$5,000 is a family maximum;
- Or if you spouse is physically or mentally incapable of self-care or is a registered full-time student, you may consider spouse's earned income of \$200 monthly (\$400 monthly if you have 2 or more dependents).

## Forfeiture of Contributions

Per IRS regulations, if you do not spend all the money in your Flexible Dependent Care Reimbursement Account during the time you are eligible for the Plan, you forfeit the amount remaining. Please keep in mind, because of this "use it or lose it" provision; you should plan your anticipated expenses carefully before electing your expense account total.

## Eligibility

Regular staff or faculty who are paid by the University and are scheduled to work at least 50 percent of a normal full-time work schedule in your department and who have a minimum appointment of six months or more are eligible to enroll in the Flexible Dependent Care Reimbursement Account. Note: Post Doctoral Fellows/Research Associates and those holding visiting appointments are excluded because of their temporary status.

## Enrollment

Eligible employees may enroll within 31 days from their date of hire or appointment, or within 31 days of when you first receive your benefits information, whichever is later. You may also enroll during the annual open

enrollment period (usually held in November) for the Plan Year beginning January 1. A Plan Year is defined as the calendar year.

A Flexible Reimbursement Account Enrollment form must be completed and submitted to the Benefits section of the Office of Human Resources. The effective date of your Flex Account will be the first of the month that coincides with or immediately follows your date of hire or your enrollment deadline. Applications submitted during the open enrollment period are effective for the Plan Year beginning January 1. Expenses incurred before participation began or after participation has terminated cannot be reimbursed.

Important Note: Flexible Reimbursement Accounts do not roll over from year to year. You must submit a new application during the annual open enrollment period if you want to participate in the following year.

### **Change in Amount Deducted**

According to IRS regulations, once you have indicated the amount you wish to have credited to your Flexible Dependent Care Reimbursement Account, you may not begin, stop or change this amount during the plan year, with the exception of certain changes in family status or employment status.

## **Change in Status – (Qualifying Events/Other Permissible Events)**

IRS regulations under Section 125 of the Internal Revenue Code require that once you have made your pre-tax election for coverage, you may not change them during the plan year unless you have a qualifying change in status or other permissible event. If you request an election change, it must be on account of and correspond with the change in status. If you experience a change in status, or other permissible event, you must contact the Benefits section of the Office of Human Resources and Employee Relations within 31 days of the event; otherwise, you will need to wait until the next annual open enrollment. The plan administrator reserves the right to review and interpret all requests for a benefit change due to a change in status or other permissible event.

### **Qualifying Events**

1. Change in legal marital status, including marriage, death of spouse, divorce, legal separation or annulment;
2. The birth, adoption or placement for adoption of a child;
3. Death of a spouse or dependent;
4. You, your spouse or eligible dependent has a change in job status that effects eligibility for benefits coverage under the University plan or a plan of your spouse or eligible dependent's employer; or
5. You, your spouse, or eligible dependent begins or returns from an unpaid leave of absence.

### **Other Permissible Events**

- If you are participating in the Flexible Dependent Care Reimbursement Account, a change in your dependent care provider will be treated as a change in available coverage that will allow you to adjust your coverage level for the balance of the plan year.
- If your daycare provider cost under the Flexible Dependent Care Reimbursement Account, significantly increases or coverage is significantly curtailed, you may change your current election and elect similar coverage offered by the University for the balance of the plan year. Cost increases imposed by a day care provider who is your relative shall not be considered significant and your Flexible Dependent Care Reimbursement Account election cannot be changed for the balance of the plan year on account of such increases.

Proof of the changes are required and reviewed before any change in the amount deposited will be approved.

## Effective Date of Change in Status

The change will be effective the date of the event, i.e., date of birth or marriage.

Contact the Benefit section of the Office of Human Resources within 31 days of a change in status. Otherwise, you will not be able to make a change in status until the next annual open enrollment period. The Plan Administrator reserves the right to review and interpret all requests for a benefit change due to a qualifying event.

### Plan Administrator Adjustments to Your Deposits

If necessary, the Brandeis Plan Administrator may increase, reduce, suspend or stop your deposit amounts at any time if:

- An adjustment needs to be made in your pay period deposit in order to meet your annual election amount (i.e. number of pay periods changes, deposit not taken from scheduled paycheck);
- Your salary, after your flexible reimbursement account contributions are deducted, does not cover the contribution to your other University benefit plans;
- To meet IRS regulations;
- If the Plan is terminated.

### Non-Discrimination Compliance Changes by Plan Administrator

If the Plan Administrator determines, before or during any Plan Year, that the Plan or any benefit option under the Plan may fail to satisfy for such Plan Year any non-discrimination requirement imposed by the Internal Revenue Code or any limitation on benefits provided to Highly Compensated or Key employees, the Administrator shall impose a pro-rata reduction on the benefit elections of all Highly-Compensated or Key employees sufficient to assure compliance with such requirement or limitation.

## End of Employee Deposits

Your before tax contributions to your Flexible Dependent Care Reimbursement Account end at the end of the plan Year or when you become ineligible for benefits. You become ineligible if you reduce your work schedule to less than half-time, transfer to an ineligible position, transfer to an approved unpaid leave of absence, terminate your employment or retire from the University. However, you may continue to submit claims for reimbursement from your account for expenses that occurred before the date you became ineligible.

If you die during a plan year, your dependents may be reimbursed from your unused account balances for eligible expenses up until your date of death. Claims must be submitted within 120 days of your death.

### Forfeited Deposits

Each Plan year you can use the Flex Reimbursement Account to pay for eligible expenses you incur during that plan year or until you become ineligible for the plan. However, your account will remain open for three months beyond the end of that plan year. You can be reimbursed for expenses you incurred during that plan year but were not billed to you until after the year ended. Reimbursements during this three-month period can only be made from the prior year's account for expenses incurred during that prior year.

**Remember that any money left in your Dependent Care Reimbursement Account three months after the end of a plan year will be forfeited.** This restriction has been imposed by the IRS in return for the tax advantages provided by the accounts. Forfeited funds will be used by the University to defray costs of the administration of the plan.

### Effects on Your Salary

The reduction in your salary to make Flex Account deposits are made on a before tax basis each pay period. Participation in this plan will not affect your salary for purposes of annual salary reviews, contributions by you or the University to the basic retirement plan, or the amount of your life insurance or disability benefits. These benefits will all continue to be based on your salary before reduction. This means that it reduces your salary subject to the Social Security tax which will result in minimal decreases in social security benefits for most participants whose salary is below the Social Security wage base.

# Claims Procedures

When you have an eligible expense during the year you can file a claim against your Flexible Dependent Care Reimbursement Account. The University has chosen Crosby Benefit Systems, Inc., a third party administrator, to process reimbursements to you from your Flexible Dependent Care Reimbursement Account. All expenses you claim for reimbursement must be for services you received during the plan year while you were participating in the plan.

To file a claim, you must complete a Dependent Care Reimbursement Request Form and attach the original receipt (cancelled checks are not sufficient) showing the service provided, the name(s) of the covered dependent(s), the provider's name, address, provider tax ID number, the date the service was rendered, and the expenses.

Submit the reimbursement form(s) with supporting documentation directly to: Crosby Benefits Systems, PO Box 929125, Needham, MA 02492-9125.

**Remember, you cannot take a federal tax deduction or credit on your income taxes for expenses reimbursed through these accounts.**

## Deadline to Submit Claims

You have three months following the end of a plan year (March 31) to turn in expenses incurred during the plan year for reimbursement. However, **the IRS requires that any funds not used by the end of this period must be forfeited.** Because of this forfeiture requirement, it is essential that you estimate your expected dependent care expenses carefully.

## Reimbursement of Claims

Generally, dependent care reimbursement requests are processed within 4 business days of the date claims are received by Crosby and are reimbursed twice each month, on the 15<sup>th</sup> and last business day of the month. You are paid the full amount of your claim up to your contribution balance. Dependent care expenses in excess of the contribution balance will remain in the account until a contribution is posted.

# FLEXIBLE HEALTH CARE REIMBURSEMENT ACCOUNT

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## Benefit Overview

A Flexible Health Care Reimbursement Account allows you to set aside a portion of your salary for non-reimbursed medical expenses on a pre-tax basis (meaning the federal, state and social security taxes will not be taken). The portion of salary elected is placed into a health care expense account and is reimbursed to you as you incur expenses from the date of enrollment through the end of the plan year (Plan year runs from January 1<sup>st</sup> through December 31<sup>st</sup>). The amount you elect to set aside will be deducted in equal amounts from your paychecks.

## Flexible Health Care Reimbursement Account

The account may be used to reimburse the participant for medical care expenses which is defined as a deductible expense for federal income tax purposes, but which has not been or will not be reimbursed by any other source, and which will not be deducted on the employee's income tax return

## Eligible Health Care Expenses

The following is a partial list of expenses that may be eligible for reimbursement through the Flexible Health Care Reimbursement Account:

- Deductibles, coinsurance and co-payments under your medical and/or dental insurance plan;
- Eyeglasses, contact lenses and necessary supplies;
- Dental expenses (other than cosmetic) not covered or not paid in full by insurance;
- Over-the-Counter Medications used to treat a specific medical condition or injury.

Also, IRS Publication 502, Medical and Dental Expenses, has a checklist of medical expenses that may be deducted and are therefore reimbursed under this plan. It also includes a list of expenses that may not be deducted. This publication is available on-line at [www.irs.ustreas.gov](http://www.irs.ustreas.gov). Note: The publication lists insurance premiums however you cannot use the Health Care Reimbursement Account to reimburse you for your health and/or dental insurance premiums, Long Term Care premiums or COBRA premium payments.

### **Contribution Limits**

Under the provision of the Flexible Health Care Reimbursement Account, you can elect a minimum of \$200 to a maximum of \$4,000 annually to be deducted in equal amounts from your paychecks on a pre-tax basis.

## **Forfeiture of Contributions**

Per IRS regulations, if you do not spend all the money in your Flexible Health Care Reimbursement Account during the time you are eligible for the Plan, you forfeit the amount remaining. Please keep in mind, because of this “use it or lose it” provision; you should plan your anticipated expenses carefully before electing your expense account total.

## **Eligibility**

Regular staff or faculty who are paid by the University and are scheduled to work at least 50 percent of a normal full-time work schedule in your department and who have a minimum appointment of six months or more are eligible to enroll in the Flexible Dependent Care Reimbursement Account. Note: Post Doctoral Fellows/Research Associates and those holding visiting appointments are excluded because of their temporary status.

## **Enrollment**

Eligible employees may enroll within 31 days from their date of hire or appointment, or within 31 days of when you first receive your benefits information, whichever is later. You may also enroll during the annual open enrollment period (usually held in November) for the Plan Year beginning January 1. A Plan Year is defined as the calendar year.

A Flexible Reimbursement Account Enrollment form must be completed and submitted to the Benefits section of the Office of Human Resources. The effective date of your Flex Account will be the first of the month that coincides with or immediately follows your date of hire or your enrollment deadline. Applications submitted during the open enrollment period are effective for the Plan Year beginning January 1. Expenses incurred before participation began or after participation has terminated cannot be reimbursed.

Important Note: Flexible Reimbursement Accounts do not roll over from year to year. You must submit a new application during the annual open enrollment period if you want to participate in the following year.

### **Change in Amount Deducted**

According to IRS regulations, once you have indicated the amount you wish to have credited to your Flexible Health Care Reimbursement Account, you may not begin, stop or change this amount during the plan year, with the exception of certain changes in family status or employment status.

## **Change in Status – (Qualifying Events)**

IRS regulations under Section 125 of the Internal Revenue Code require that once you have made your pre-tax election for coverage, you may not change them during the plan year unless you have a qualifying change in status or other permissible event. If you request an election change, it must be on account of and correspond with the change in status. If you experience a change in status, or other permissible event, you must contact the Benefits section of the Office of Human Resources and Employee Relations within 31 days of the event; otherwise, you will need to wait until the next annual open enrollment. The plan administrator reserves the right to review and interpret all requests for a benefit change due to a change in status or other permissible event.

### **Qualifying Events**

6. Change in legal marital status, including marriage, death of spouse, divorce, legal separation or annulment;
7. The birth, adoption or placement for adoption of a child;
8. Death of a spouse or dependent;
9. You, your spouse or eligible dependent has a change in job status that effects eligibility for benefits coverage under the University plan or a plan of your spouse or eligible dependent's employer; or
10. You, your spouse, or eligible dependent begins or returns from an unpaid leave of absence.

Proof of the changes are required and reviewed before any change in the amount deposited will be approved.

### **Effective Date of Change in Status**

The change will be effective the date of the event, i.e., date of birth or marriage. Contact the Benefit section of the Office of Human Resources within 31 days of a change in status. Otherwise, you will not be able to make a change in status until the next annual open enrollment period. The Plan Administrator reserves the right to review and interpret all requests for a benefit change due to a qualifying event.

#### **Plan Administrator Adjustments to Your Deposits**

If necessary, the Brandeis Plan Administrator may increase, reduce, suspend or stop your deposit amounts at any time if:

- An adjustment needs to be made in your pay period deposit in order to meet your annual election amount (i.e. number of pay periods changes, deposit not taken from scheduled paycheck);
- Your salary, after your flexible reimbursement account contributions are deducted, does not cover the contribution to your other University benefit plans;
- To meet IRS regulations;
- If the Plan is terminated.

### **End of Employee Deposits**

Your before tax contributions to your Flexible Health Care Reimbursement Account end at the end of the plan year or when you become ineligible for benefits. You become ineligible if you reduce your work schedule to less than half-time, transfer to an ineligible position, transfer to an approved unpaid leave of absence, terminate your employment or retire from the University. However, you may continue to submit claims for reimbursement from your account for expenses that occurred before the date you became ineligible. You may be eligible to continue participating in the Flexible Health Care Reimbursement Account under the provisions of COBRA. Your contributions to this account while you are on COBRA must be made on an after-tax basis.

If you die during a plan year, your dependents may be reimbursed from your unused account balances for eligible expenses up until your date of death. Claims must be submitted within 120 days of your death.

#### **Forfeited Deposits**

Each Plan year you can use the Flex Health Care Reimbursement Account to pay for eligible expenses you incur during that plan year or until you become ineligible for the plan. However, your account will remain open for three months beyond the end of that plan year. You can be reimbursed for expenses you incurred during that plan year but were not billed to you until after the year ended. Reimbursements during this three-month period can only be made from the prior year's account for expenses incurred during that prior year.

**Remember that any money left in your Health Care Reimbursement Account three months after the end of a plan year will be forfeited.** This restriction has been imposed by the IRS in return for the tax advantages provided by the accounts. Forfeited funds will be used by the University to defray costs of the administration of the plan.

### **Effects on Your Salary**

The reduction in your salary to make Flex Account deposits are made on a before tax basis each pay period. Participation in this plan will not affect your salary for purposes of annual salary reviews, contributions by you or the University to the basic retirement plan, or the amount of your life insurance or disability benefits. These benefits will all continue to be based on your salary before reduction. This means that it reduces your salary subject to the Social Security tax which will result in minimal decreases in social security benefits for most participants whose salary is below the Social Security wage base.

## **Claims Procedures**

When you have an eligible expense during the year you can file a claim against your Flexible Health Care Reimbursement Account. The University has chosen Crosby Benefit Systems, Inc., a third party administrator, to process reimbursements to you from your Flexible Health Care Reimbursement Account. All expenses you claim for reimbursement must be for services you received during the plan year while you were participating in the plan.

To file a claim, you must complete a Health Care Reimbursement Request Form and attach the original receipt (cancelled checks are not sufficient) showing the service provided, the name(s) of the covered dependent(s), the provider's name, address, provider tax ID number, the date the service was rendered, and the expenses.

Submit the reimbursement form(s) with supporting documentation directly to: Crosby Benefits Systems, PO Box 929125, Needham, MA 02492-9125.

### **Deadline to Submit Claims**

You have three months following the end of a plan year (March 31) to turn in expenses incurred during the plan year for reimbursement. However, **the IRS requires that any funds not used by the end of this period must be forfeited.** Because of this forfeiture requirement, it is essential that you estimate your expected health care expenses carefully.

### **Reimbursement of Claims**

Generally, health care reimbursement requests are processed within 4 business days of the date claims are received by Crosby and are reimbursed twice each month, on the 15<sup>th</sup> and last business day of the month. Health care expenses in excess of the contribution balance will be reimbursed in full up to the annual maximum elected even if contributions are not yet posted to the account.

# **GROUP TRAVEL ACCIDENT INSURANCE PLAN**

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## **Overview of Benefit**

Employees are insured for injuries sustained while on the business of the University and during the course of any bona fide trip, excluding everyday travel to and from work and bona fide vacations. The term "while on the

business of the University” means during any trip authorized by or at the direction of the University for the purpose of furthering the business of the University. Furthermore, for such trips, the University makes travel arrangements and the insured is entitled to reimbursement by the University if not otherwise reimbursed by another organization as described as follows: “Business of the policyholder” shall include, but not be limited to paid or unpaid participation in off-campus academic or administrative conferences, lectures, committee meetings or research while such events are sponsored by a government or non-profit organization and coverage begins when you leave your place of residence or regular place of employment.

## **Eligibility**

All Faculty members are eligible for the Group Travel Accident Insurance Plan.

### ***Definition of Injury***

“Injury” means bodily injury caused by an accident which occurs while this policy is in force as to the Insured Person, which results directly in loss covered by this policy and is sustained independently of all other causes under the circumstances and in the manner described in the “Description of Hazards”.

### ***Definition of Loss***

Loss as used in the Accidental Death & Dismemberment schedule with reference to hand or foot means the actual and complete severance through or above the wrist or ankle joint; as used with reference to eye means irrecoverable loss of entire sight thereof; as used with reference to speech means complete and irrecoverable loss of speech; as used with reference to hearing means complete and irrecoverable loss hearing in both ears; and as used with respect to thumb and index finger means the actual and complete severance through or above the metacarpophalangeal joints.

<b>Schedule of Benefits</b>	
Accidental Death and Dismemberment Benefit	\$250,000
Loss of Life	100%
Loss of Both Hands or Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of Speech and Hearing	100%
Loss of either Hand or Foot, and Sight of one Eye	100%
Loss of Movement of Both Upper and Lower Limbs (Quadriplegia)	100%
Loss of Movement of Both Lower Limbs (Paraplegia)	75%
Loss of Movement of Both Upper and Lower Limbs of one Side of the Body (Hemiplegia)	50%
Loss of Either Hand or Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Speech	50%
Loss of Hearing in Both Ears	50%
Loss of Thumb & Index Finger of Same Hand	25%
Medical Expenses per Accident Maximum Limit (Excess of All Other Insurance)	\$2,500
Weekly Indemnity Disability Payments (Maximum of 52 Weeks)	\$100

Accidental Death and Dismemberment Reduction on and after Age 70: On the date of the insured person's attainment of ages 70, 75, 80, and 85, the insured person's amount of Principal Sum (\$250,000) will reduce. The reduced amount will be determined by multiplying the amount of Principal Sum shown in the schedule and applicable to the insured person by the percentage shown below for his or her attained age:

Insured Person's Age	Percentage of Principal Sum
Age 70 – 74	65%
Age 75 – 79	45%
Age 80 – 84	30%
Age 85 or over	15%

Insured Persons age 70 or over will be eligible for a Principal Sum amount that is more than the percentage of Principal sum shown above for his or her attained age.

## Exclusions

This policy does not cover loss caused by, contributed to or resulting from:

- Intentionally self inflicted injury, suicide or attempted suicide, whether sane or insane;
- War or act of war, whether declared or undeclared;
- Injury sustained while in the armed forces of any country or international authority; or
- Injury sustained while on any aircraft, unless, and only to the extent, a hazard specifically describes such coverage.

### Claims Procedure

Any participant or beneficiary under the Plan (or his or her duly authorized representative) may submit to the Plan Administrator a claim for benefits within 20 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as reasonable possible. The appropriate claim forms for applying for benefits and assistance in the completion of these forms may be obtained from the Benefits section of the Human Resources and Employee Relations Office. The forms, when completed, will be forwarded by the Plan Administrator to the Insurance Agent.

## Payment of Benefits

If, at the death of the insured, there is no surviving beneficiary, the accidental loss of life indemnity shall be payable in one sum to the beneficiary designated on the Group Life Plan, if no beneficiary is designated, then to the first surviving class of the following classes of beneficiaries: spouse, child or children, parents, brothers or sisters. Otherwise, it shall be payable to the estate of the insured. A benefit designation card for the Group Term Life Insurance Plan is available in the Benefits section, Office of Human Resources and Employee Relations.

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# LONG TERM CARE INSURANCE

### Benefit Overview

Through the sponsorship of The Boston Consortium, Brandeis University is able to offer its eligible employees the opportunity to purchase Group Long Term Care Insurance through CNA Insurance Company for both themselves and their family members. Long Term Care Insurance covers a portion of the costs of nursing home stays and home health care visits that are not adequately covered by group health plans, other insurance or government programs. Employees may request a copy of the plan brochures from the Benefit section of the Office of Human Resources and Employee Relations.

### Eligibility

Regular full-time and benefit eligible part-time faculty are eligible to enroll with guaranteed issue during their first 30 days from their date of hire. Eligible employees who do not enroll during their initial enrollment period may enroll at a future date however you will be required to provide evidence of insurability to CNA before any coverage would become effective.

Coverage is also available for certain family members of the eligible employee. Spouses and/or same-sex domestic partners are eligible to enroll at any time but are not guaranteed issue by CNA Insurance. A short form application regarding their health status must be completed. Coverage is also available at any time for parents, parents-in-law, grandparents and grandparents-in-law under the age of 80 however they are not guaranteed issue by CNA Insurance. A long form application regarding their health status must be completed. Enrollment is subject to insurance company approval.

## **Important Note**

The Benefits section of the Office of Human Resources and Employee Relations does not administer this benefit. All inquiries should be made directly to CNA representative at 1-877-777-9072. If you elect to enroll in the Long Term Care Plan, CNA Insurance will forward you a copy of the Summary Plan Description.

## **SOCIAL SECURITY**

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Faculty contribute through payroll deduction to the Social Security Fund and Medicare Fund administered by the federal government. The University contributes an equal amount on behalf of each employee. Law mandates the amount of these contributions. Contributions are intended to provide a portion of retirement income, disability benefits, spousal benefits, surviving children's benefits, and Medicare benefits.

<b>Effective Date</b>	<b>Tax Rate</b>	
2006	FICA	6.20% of the first \$94,200* of earnings
	MEDICARE	1.45% on all earnings

\*Figure subject to change annually.

## **UNEMPLOYMENT COMPENSATION**

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Faculty working in Massachusetts may apply for Unemployment Insurance benefits under the Massachusetts Employment Security Act if their employment is terminated by the University for reasons other than for cause. Unemployment Insurance provides partial salary replacement to eligible individuals who, although ready, willing, and able to work, are unable to find suitable employment. Benefit payments attributable to Brandeis University employment are paid entirely by the University by reimbursing the state for the amount of the benefits paid. No deductions are made from the salaries of faculty for purposes of providing unemployment coverage.

## **WORKERS' COMPENSATION**

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Faculty members are covered by the laws of the Commonwealth of Massachusetts relating to Worker's Compensation Insurance. The coverage provides a weekly cash benefit and payment for medical expenses relating to an accidental injury while at work for the University. The University has elected to self-insure for Worker's Compensation. If you are hurt while at work for the University, please contact the Office of Human Resources and Employee Relations as soon as possible.

Health and dental benefits will continue on a cost-sharing basis based on length of service with the following schedule:

Length of Continuous Employment	Length of Coverage
Up to 2 years	3 months
2 to 5 years	6 months
5 to 9 years	9 months
Over 9 years	12 months

After this period, individuals may remain in the plan at their own expense until the disability ceases and they are able to return to work or when they reach age 65, whichever comes first. Every effort will be made to ensure that an appropriate open position is available when the injured individual is able to return to work. However, no position will be held open longer than 12 months.

## TUITION REMISSION for EMPLOYEES

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### Benefit Overview

Faculty members who have appointments of at least half-time status may enroll in Brandeis University courses and receive up to 100% tuition remission, on a seats-available basis only. Courses can be taken from any of the schools at the University:

- The College of Arts and Sciences (undergraduate and graduate courses)
- The Heller School of Social Policy and Management
- The International Business School (IBS)
- The Rabb School for Summer and Continuing Studies

Eligible faculty may take courses for academic credit or they may audit courses on a seats-available basis. Employees may take one course per semester, for a total of three (3) courses per calendar year. A fourth course is possible if both Summer semester courses are taken during both Summer School sessions. Eligible individuals may be given permission to take two courses in one semester upon receipt of a written request from their department head with the understanding that a maximum of no more than three courses taken will be approved in one calendar year. Tuition remission does not extend to any fees, which include registration, matriculation, late and special course fees.

Module courses (course numbers ending in “f”) are courses in the Heller or IBS programs that are worth half as much as regular courses, in course duration, cost and credits. Two (2) of these module courses will count as one (1) regular course for the maximum course limitations as stated above.

### Eligibility

Following three months of consecutive employment, **full-time** faculty members are eligible to receive 100% tuition remission for one Brandeis University course per semester.

Following three months of consecutive employment, **part-time** faculty members who are half time status or more are eligible to receive pro-rated tuition remission for one course per semester. The amount to be pro-rated will depend upon the faculty member’s full-time equivalency (FTE). For example, an employee who is considered at .75 FTE would receive a 75% reduction in the cost of the course.

### To Apply

All employees wishing to enroll in a course must complete a Tuition Remission application, which can be found in the Office of Human Resources and Employee Relations or online at [www.brandeis.edu/humanresources/careers/benefits.html#education](http://www.brandeis.edu/humanresources/careers/benefits.html#education). All faculty members must have his or her Chairperson and the course instructor sign the tuition remission application before its submission. The Director

of Benefits grants final approval for tuition remission requests. Tuition remission applications for courses in the Rabb School of Continuing Studies or the Summer School Program will not need an instructor signature in order to submit the tuition remission application. Tuition remission will be pending until the employee has formally registered with the Continuing Studies Office or the Summer School Office.

## Course Registration and Billing

Employees do not have to officially register for most of their classes. Once the tuition remission application is received and approved, the Office of Human Resources and Employee Relations transmits the employee's course information to the Registrar's Office.

**Please note:** The tuition remission application process DOES NOT constitute registration for the **Summer School Program** or **Continuing Studies** courses. You must contact those offices directly to register for courses, which will be on a seats-available basis only.

The Registrar enrolls all employees as "Special Students". Since regular students receive preference for available seats, applications for tuition remission do not guarantee enrollment for employees. If an employee is waitlisted, the Benefits section will notify him or her. Employees wishing to matriculate in a Brandeis degree program must contact the appropriate admissions office about enrollment requirements.

Employee tuition remission information is also sent to the Bursar's Office to be credited on the employee's student account. Tuition remission benefits do not extend to any registration fees or late and special course fees. If an employee received a pro-rated tuition remission benefit, he or she will be responsible for the remainder of the charges on their student account.

### Dropping/Withdrawing a Class

If an employee wishes to drop or withdraw from a course for which they received tuition remission, they must complete a formal Add/Drop form from the Registrar's Office. The employee is also required to notify the Benefits section of the Office of Human Resources and Employee Relations of the course they intend to drop. Tuition remission benefits payable or partially payable on the student's behalf will still count towards the employee's calendar year limit of courses.

### Taxation of Graduate Level Tuition Benefits

The Federal and Massachusetts State governments mandate that any tuition remission received for graduate level courses that are NOT job related are subject to State, Federal and FICA taxation once the total amount of benefits exceeds \$5,250 in a calendar year. **If the selected course(s) is (are) job related, there is no taxation at all on the State or Federal level.**

All employees declaring that they are taking job-related graduate courses at Brandeis University must complete a **Tuition Remission Taxation Waiver form** and submit it along with the tuition remission application. If no form is submitted, employees will be taxed under the law as it currently stands.

Tax withholding will apply on a Graduate level course with tuition payable or partially payable if the course is dropped after the designated drop date established for students. Taxes must be deducted out of the current calendar year. If you notify us of your intention to take a taxable course and there is limited time until December 31<sup>st</sup> of the current year, we reserve the right to readjust the taxable gross amount on your W-2 form in order to comply with Federal and/or State law.

**Important Note:** The University reserves the right to modify or discontinue the tuition remission programs at any time. In the event of discontinuance, a student will receive tuition remission for the semester in progress.

TUITION REMISSION for EMPLOYEE  
**SPOUSES / SAME SEX DOMESTIC PARTNERS**

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## Benefit Overview

Spouses or same sex domestic partners of eligible faculty may enroll in Brandeis University **undergraduate courses** and receive 75% tuition remission. Courses may be taken from the College of Arts and Sciences or the Rabb Summer School Program. Spouses or same sex domestic partners may enroll on a seats-available basis only.

Employee spouses or same sex domestic partners may take one course per semester, for a total of 3 courses per calendar year. A fourth course is possible if both summer semester courses are taken during both Summer School sessions. Tuition remission does not extend to any registration fees or late and special course fees.

**Please note:** Employees, who have same sex domestic partners that receive tuition remission benefits, will be taxed on the amount of the benefit.

## Eligibility

To be eligible, the student must be the legal spouse or the declared same sex domestic partner of a full-time faculty member that has been employed consecutively at Brandeis University for at least 3 months. Spouses or same sex domestic partners of part-time faculty members are not eligible for this benefit.

## Course Enrollment and Billing

Employees wishing to enroll their spouse or same sex domestic partner in a course must complete a Tuition Remission for Qualified Dependent application, which can be found in the Office of Human Resources and Employee Relations or online at [www.brandeis.edu/humanresources/careers/benefits.html#education](http://www.brandeis.edu/humanresources/careers/benefits.html#education). The same registration process for regular employees will be used for employee spouses and same sex domestic partners. Spouses and same sex domestic partners will also be considered as "Special Students" unless they formally matriculate in a Brandeis University degree program. The student will be responsible for any remaining balance left on their student account.

**Please note:** Application for tuition remission DOES NOT constitute registration in the Summer School Program. Registration for the Summer School program is done directly with the Summer School office.

## TUITION REMISSION for DEPENDENT CHILDREN

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### Benefit Overview

Dependent children of eligible faculty members may receive tuition remission benefits when they are accepted and enrolled in a full-time undergraduate academic program either at Brandeis University or another higher educational institution. These benefits are applicable to tuition only and do not include room and board or any other expenses. These benefits are applicable for four (4) undergraduate academic years, or eight (8) undergraduate semesters, which need not be consecutive. If both parents are employed by the University the dependent child will only receive benefits under one parent. These benefits do not apply to graduate study. These programs may be revised or amended by the University at any time without notice.

### Eligibility

The eligibility requirements for dependent tuition remission benefits are as follows:

1. One of the parents is:
  - a. A full-time professor, associate professor, assistant professor, senior scientist or senior fellow at Brandeis University;
  - b. A full-time instructor, lecturer, artist-in-residence, or adjunct faculty member at Brandeis University who has completed three years of consecutive full-time service;
  - c. Or deceased or retired by Brandeis University and the date of death or retirement was July 1969 or later and on the date of death or retirement, such parent was a full-time professor, associate professor, or assistant professor of the University and had been in its employment for a period of

five years or more. **This provision is limited to tuition remission at Brandeis University only and does not apply to tuition remission at other colleges or universities.**

2. The student is a natural born, adopted, foster child or stepchild. A foster child must have resided in the faculty member's home for five years prior to enrollment, and the faculty member must have primarily supported the foster child. **Proof of dependency under IRS regulations is required.**
3. The student meets all the requirements for admission and is accepted to Brandeis University or another accredited college or university in a full-time program leading to an undergraduate degree.

### **Children Attending Brandeis University**

Dependent children of eligible faculty members that are accepted into Brandeis University's undergraduate program are eligible for 75% tuition remission of the University's tuition charge. This benefit is applicable to tuition only and does not include room and board or any other expenses. Other tuition remission, including scholarships received by the student, may reduce this benefit by that portion of the other benefit that is over 25% of the Brandeis University tuition.

Applications for this benefit are available to eligible faculty members by contacting the Benefits section in the Office of Human Resources and Employee Relations, Gryzmish 106. All applications must be completed and forwarded to the Director of Benefits a minimum of two months prior to the semester for which the tuition remission is desired. A photocopy of the top portion of the latest IRS form listing the student as a dependent must be submitted before the tuition remission benefit will be granted. Faculty members must reapply for this benefit every academic year.

If the parent of the child receiving tuition remission ceases his or her employment with the University or changes status from full-time to part-time employment, tuition remission ceases at the end of the semester in which the termination or change in status occurs. The only circumstances under which this rule will be waived and the child permitted to complete the undergraduate program is if the termination results from retirement (at age 62 or older), or total disability or death.

### **Children Attending Other Educational Institutions**

Dependent children of eligible faculty members can receive tuition remission when they are enrolled in a full-time undergraduate program at an accredited college or university, leading to an undergraduate academic degree. Conditions are as follows:

#### **Faculty hired and/or eligible prior to December 31, 1984**

The tuition remission benefit amount will be equal to 75% of the other institution's tuition cost up to 75% of the current Brandeis University cost, whichever is less.

#### **Faculty hired and/or eligible on or after January 1, 1985**

A tuition remission benefit of \$3,500 (effective Fall 1995) per year for 4 undergraduate years or 75% of another institution's tuition, whichever is less, is provided to meet tuition costs at an institution other than Brandeis University.

Sabbatical leave time is included in the calculation of service for the purpose of eligibility under conditions stated in Section 1c above. Other leaves of absence are not considered in computing service.

Other tuition remission, including scholarships received by the student, may reduce this benefit by that portion of the other benefit that is over 25% of the tuition of the institution.

Upon receipt of application, a letter will be sent to the school to verify the student's attendance and the tuition charges. Once all required information is received, the Office of Human Resources and Employee Relations will send payments directly to the institution for the academic year.

### **Application**

To apply for these tuition remission benefits, please contact the Benefits section in the Office of Human Resources and Employee Relations. All applications must be completed and must have attached a copy of the top portion of the employee's latest IRS tax document listing the student as their dependent child. All applications must be forwarded to the Director of Benefits at MS 118 at least two months prior to the start of the semester for which tuition remission is desired. Faculty members will receive a copy of the approved tuition remission application in campus mail. Faculty members must reapply each academic year for this benefit.

### **Junior Year Abroad Students**

Room and board charges may be reimbursed if tuition charges are less than the maximum payable amounts as listed above. Any tuition remission payment used for room and board will, however, be taxable. It should be noted that any grant used for room and board would be taxable whether or not benefits under this Plan are deemed to be tax-free to the faculty member.

### **Please note TUITION REMISSION PLAN FOR DEPENDENT CHILDREN OF FACULTY MEMBERS**

**TAX:** In past years, under relevant tax guidance, the value of certain tuition assistance payments made to "Highly Compensated faculty" were considered compensation and taxed accordingly. However, early in 1995, the University was advised by legal counsel that the benefits may be treated reasonably as exempt from federal and state incomes. While Brandeis University believes the non-taxable interpretation is correct, the University cannot be certain the IRS or the Massachusetts Department of Revenue will accept this treatment of benefits. It is possible that at some future date, the University may reverse this decision and treat tuition benefits received by Highly Compensated faculty as taxable income.

## **SUMMER SCHOOL AND GENESIS PROGRAMS**

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### **Benefit Overview**

Tuition remission for dependent children is also available for certain programs on campus. On a space available basis, dependent children of eligible faculty members may also enroll and receive tuition remission in both the Summer School Program and the Genesis Program.

The **Summer School Program** is conducted through the Rabb School of Summer and Continuing Studies. High school or college-aged dependent children may take one course per session and receive 50% tuition remission per course.

The **Genesis Program** is an academic enrichment program for high school students. Eligible dependent children may be granted one-third (1/3) tuition remission (generally, 57% of the full program fee is applied toward tuition) in the Genesis Program upon acceptance to the Program.

More information on these programs can be found at [www.brandeis.edu/summer](http://www.brandeis.edu/summer) or by contacting the Summer School Office at (781) 736-3424.

### **Eligibility**

To be eligible, the student must be the dependent child of a full-time faculty member who has been employed consecutively at Brandeis University for at least three (3) months. Proof of dependency under IRS regulations is required for all applications.

### **To Apply**

All employees wishing to apply for these tuition remission benefits must complete a Tuition Remission Application for Qualified Dependents. These forms can be found in the Office of Human Resources and Employee Relations or online at [www.brandeis.edu/humanresources/careers/benefits.html#education](http://www.brandeis.edu/humanresources/careers/benefits.html#education). For more information on these programs or to register, please contact the Office of Summer and Continuing Studies.

### **Registration and Billing**

Employees wishing to enroll their dependent child in a class or program must contact the Summer School Office and complete their registration process. Employees will be responsible for the remainder of the cost of the courses, after tuition remission has been applied.

## ACTIVITIES AND SERVICES

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### Photo ID Cards

Photo ID cards are available at the Campus Card Office (ext. 64230) in the Kutz Building, Room 9 upon presentation of verification of employment from the Employment Section of the Office of Human Resources and Employee Relations. The schedule of hours when identification cards are issued is available in the Office of Human Resources and Employee Relations.

### Athletic and Recreational Activities

Faculty are welcome to utilize the facilities of the Gosman Sports and Convocation Center. To do so, your ID card is required. Faculty may purchase a pass for their spouse or dependent child. A schedule of facility hours is available by calling the Athletic Center's main office.

### Cultural Activities

Theater performances, concerts and art exhibits occur frequently during the academic year. Many of these events are free to faculty. Announcements of performances and exhibits are published in the Brandeis Reporter and may also be found at the Brandeis University web site. Additional information about performances and tickets may be obtained by contacting the appropriate department.

Theater	(781) 736-3400
Concerts	(781) 736-3331
Art Exhibits	(781) 736-3434

### Parking Privileges

All faculty who operate or park a motor vehicle (automobile, truck, motorcycle, motor scooter, or motor bike) on University property must register their vehicles and apply for a parking permit through the Public Safety Office located in the Stoneman Building. If you park in a lot without having the appropriate sticker, you will be subject to a parking ticket that may include a fine. There is no charge for parking privileges at the present time. A booklet, "Campus Parking and Traffic Regulations," is available at the Office of Public Safety.

### Use of Libraries

Your photo ID card allows you to enjoy the privileges at the University libraries.

Daycare – Lemberg Children's Center, Inc.

The Lemberg Children's Center is a non-profit cooperative day-care center located on the University campus. A professional staff assisted by parents and Brandeis students provide children with a full program of educational and recreational activities. The Center is open Monday through Friday from 8:00 a.m. to 5:45 p.m. Parents may choose one-half or three-quarter day options. Questions about the program should be addressed directly to the Center at 781-736-2200.

### The Human Resources and Employee Relations Box Office

**The Office of Human Resources and Employee Relations provides discount or free admission tickets to a number of museums, theaters, and sporting events.** The Box Office is open from 10:00 am to 2:00 pm, Thursdays and Fridays in the Office of Human Resources and Employee Relations. Payment must be made by check or money order only. All employees must show their ID.

- **Movies:** Discount tickets are available, at a substantial savings on the price of admission, to theaters in over 40 locations in Eastern Massachusetts. Currently, tickets to AMC are \$5.50, Sony (Loews) and

Showcase theaters are \$6.00, and Showcase and Landmark theaters are \$7.00 each (prices effective June 2006).

- Museum of Science: Discount tickets for museum admittance are \$3.00 each. This represents a substantial savings on the current admission price. Please note that special exhibits are not included in the general admission.
- Museum of Fine Arts: A number of free passes to the museum are available to be borrowed overnight or for a weekend. The passes are good for free admission.
- New England Aquarium: Discount tickets for the aquarium are available for \$5.00 each. This represents a substantial savings on adult admission.
- Memberships: The University maintains group memberships in such shopping/discount clubs such as Busch Gardens (includes Adventure Island, Cypress Gardens and Sea World), Universal Studios, and Mass Buying Power. Special discounted one-year memberships in the Costco Wholesale Club are arranged annually. The Benefits section of the Office of Human Resources and Employee Relations will announce the date of the membership period.

Tickets, passes or information on any of these programs are available in the Office of Human Resources and Employee Relations, Gryzmish Bldg., Room 106, extension 64469.

## **On Campus ATMs**

As a convenience to faculty members, in the Shapiro Campus Center, there is a Citizens Bank ATM. There is also a Sovereign Bank ATM located in the Usdan Student Center.

## **Auto Insurance**

As an employee of the University, you may be eligible for a discount on your auto insurance through Liberty Mutual Insurance Company. Additional information may be obtained in the Office of Human Resources and Employee Relations.

## **Bookstore**

Most items in the University Bookstore may be purchased at a 10 % discount. This includes clothing, books, jewelry, cosmetics and CDs. Candy and specially ordered books are excluded from this discount. The Bookstore is located on the lower level of the Shapiro Campus Center.

## **Credit Union**

Joining the Metropolitan Credit Union allows you to save, borrow money, obtain a VISA card, or use a variety of other available banking services. Please call ext 64468 for further information regarding Credit Union locations, possible representative campus visits and enrollment forms. Transactions are processed through payroll deductions. Information may also be found at the credit union's web site, [www.metrocreditunion.org](http://www.metrocreditunion.org).

## **Direct Deposit**

You may arrange to have your paycheck deposited directly into a checking and/or saving account. Please contact the Payroll Office regarding the procedure required to institute this process.

## **Religious Services**

Brandeis offers three chapels, the Berlin, the Bethlehem and the Harlan Chapels, representing the Jewish, Catholic and Protestant traditions. These three chapels provide regularly scheduled services throughout the year. Faculty are invited to participate. A schedule of services is listed in the Brandeis Reporter.

## **Remembrances**

The University will send flowers or a donation to a charity or institution in memory of a deceased employee or a deceased member of the employee's immediate family. When such an occurrence takes place, please notify the Office of Human Resources and Employee Relations, ext 64464, and arrangements will be made.

## **Savings Bonds**

You may purchase United States Savings Bonds through regular payroll deductions. Application forms are available in the Benefits section of the Office of Human Resources and Employee Relations.

## **University Facilities**

If you are interested in using a University facility for a personal occasion, you may make arrangements through the Office of University Events Services, at x64300.

## **Faculty Club**

Faculty are invited to join the Faculty Club. The club includes the main dining area, a private dining room, a social lounge and overnight accommodations. Information regarding membership may be obtained from the Faculty Club Manager, x64281.

## SUMMARY PLAN DESCRIPTION

The following information, together with the accompanying Benefits and Services Handbook and your Evidence of Coverage Handbook or Certificate of Insurance Handbook issued to you by Tufts Health Plan is the Summary Plan Description required by 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:** **Brandeis University Medical Insurance Plan**

**Plan Number:** **503**

**Plan Sponsor:** **Brandeis University**  
415 South Street  
Waltham, MA 02454-9110

**Plan Administrator:** **Brandeis University**  
Associate Vice President of Human Resources  
and Employee Relations  
415 South Street  
Waltham, MA 02454-9110  
(781) 736-4468

The administration of the plan shall be under the supervision of the plan administrator. To the fullest extent permitted by law, the plan administrator shall have the discretion to determine all matters relating to eligibility, coverage and benefits under the plan, and the plan administrator shall have the discretion to determine all matters relating to the interpretation and operation of the plan. Any determination by the plan administrator, or any authorized delegate, shall be final and binding, in the absence of clear and convincing evidence that the plan administrator or delegate acted arbitrarily and capriciously.

Any insurance carrier, as a claim fiduciary, has discretionary authority to construe any and all terms of the group insurance policy it has issued, and the power and discretion to determine questions of fact and law arising in connection with the administration, interpretation and application of the group insurance policy. Any and all of the claims fiduciary's decision with respect to the group insurance policy shall be conclusive and binding on all persons.

**Employer Identification Number:04-2103552**

**Agent for Service of Legal Process:** **Brandeis University**  
Associate Vice President of Human Resources  
and Employee Relations  
415 South Street  
Waltham, MA 02454-9110  
(781) 736-4468

### **Plan Year:**

The financial record of the plan is kept on a plan year basis beginning on each January 1 and ending on each December 31.

### **Administration of Medical Insurance Plan:**

The Plan is administered by the Plan Administrator with benefits provided in accordance with the provision of the applicable group policy issued by Tufts Health Plan. The Plan is fully-insured. Tufts Health Plan, 333 Wyman Street, Waltham, MA, 02454 is solely responsible for financing and providing the benefits under the insurance policies and contracts. The University has no liability for any benefits due, or alleged to be due, under any such insurance policies or contracts.

### **Circumstances which may result in disqualification of eligibility, denial, forfeiture or suspension of benefits:**

as set forth in the accompanying Benefits and Service Handbook

### **Plan Funding:**

The Plan is financed by contributions from the Plan Sponsor and from participating employees.

### **Amendment and Termination of Plans:**

Brandeis University has established the Plan with the bona fide intention and expectation that it will be continued

indefinitely, but the University shall not have any obligation whatsoever to maintain a Plan for any given length of time. The University, by action of its Board, also may delegate any of its power and duties with respect to the Plan or its amendments to one or more officers or other employees of the University. Any such delegation shall be stated in writing. The University will exercise good faith, apply standards of uniform application, and refrain from arbitrary action.

No vested rights of any nature are provided under the Medical plan. Any medical claims or expenses incurred before the date of any plan amendment or termination will be paid in accordance with the plan terms in effect at the time the claim or expense was incurred; provided the claim is filed with the Plan in accordance with the applicable claims procedures and within the applicable time limits for filing such claims.

**No Employment Rights:**

Neither the Plan nor this summary creates an employment contract nor any right to continued employment at Brandeis University.

**Union Agreements:**

The Plan is maintained, in part, pursuant to one or more collective bargaining agreements. You may obtain a copy of the agreements at any reasonable time at the office of the Plan Administrator.

**Support Order Procedures:**

Upon request, copies of the University's procedures for Qualified Medical Child Support Orders (QMCSOs) may be obtained from the Plan Administrator free of charge.

**Claims Procedures:**

Under certain circumstances, you may be required to file a claim form to obtain benefits. Any required claim forms are available from Tufts Health Plan. If you are required to complete a claim form and any benefits under the plan are denied, you have the right to request a full and fair review of your claim. If you believe you are incorrectly denied all or part of your benefits, you may appeal the benefit denial.

Please refer to your "Tufts Evidence of Coverage Handbook" or "Certificate of Insurance Handbook" for a summary of claim procedures and appeal processes. Information can be found under the Satisfaction Process section of your handbook.

**STATEMENT OF ERISA RIGHTS**

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

**Receive Information About Your Plan and Benefits**

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 furnish each participant with a copy of this summary annual report.

***Continue Group Health Plan Coverage***

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under health care plans as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review these summary plan descriptions and the documents governing the health care plans on rules governing your COBRA coverage.
- Reduce or eliminate any exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled 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 month after losing coverage. Without

evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

#### **Prudent Actions by Plan Fiduciaries**

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

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

#### **Enforce Your Rights**

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such 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 administrator.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, 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 domestic relations order or 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 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 who has sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

#### **Assistance with Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.

### **SUMMARY PLAN DESCRIPTION**

The following information, together with the accompanying Benefits and Services Handbook and your Subscriber Certificate issued to you by Brandeis University is the Summary Plan Description required by 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:** Brandeis University Dental Insurance Plan

**Plan Number:** 511

**Plan Sponsor:** Brandeis University  
415 South Street  
Waltham, MA 02454-9110

**Plan Administrator:** **Brandeis University**  
Associate Vice President of Human Resources  
and Employee Relations  
415 South Street  
Waltham, MA 02454-9110  
(781) 736-4468

The administration of the plan shall be under the supervision of the plan administrator. To the fullest extent permitted by law, the plan administrator shall have the discretion to determine all matters relating to eligibility, coverage and benefits under the plan, and the plan administrator shall have the discretion to determine all matters relating to the interpretation and operation of the plan. Any determination by the plan administrator, or any authorized delegate, shall be final and binding, in the absence of clear and convincing evidence that the plan administrator or delegate acted arbitrarily and capriciously.

Any insurance carrier, as a claim fiduciary, has discretionary authority to construe any and all terms of the group insurance policy it has issued, and the power and discretion to determine questions of fact and law arising in connection with the administration, interpretation and application of the group insurance policy. Any and all of the claims fiduciary's decision with respect to the group insurance policy shall be conclusive and binding on all persons.

**Employer Identification Number:04-2103552**

**Agent for Service of Legal Process:** **Brandeis University**  
Associate Vice President of Human Resources  
and Employee Relations  
415 South Street  
Waltham, MA 02454-9110  
(781) 736-4468

**Plan Year:**

The financial record of the plan is kept on a plan year basis beginning on each January 1 and ending on each December 31.

**Administration of Dental Insurance Plan:**

The Plan is administered by the Plan Administrator with benefits provided in accordance with the provision of the applicable group policies issued by Delta Dental. The DeltaPremier Plan is self-insured. Delta Dental provides claims payment and other administrative services under an administrative contract with Brandeis University but they do not assume any financial risk or obligation with respect to claims or benefits under the coverage. The DeltaCare Plan is fully insured. Delta Dental, 465 Medford Street, Boston, MA, 02129, is solely responsible for financing and providing the benefits under the DeltaCare insurance policy and contract. The University has no liability for any benefits due, or alleged to be due, under any such insurance policies or contracts.

**Circumstances which may result in disqualification of eligibility, denial, forfeiture or suspension of benefits:**

as set forth in the accompanying Benefits and Service Handbook

**Plan Funding:**

The Plan is financed by contributions from the Plan Sponsor and from participating employees.

**Amendment and Termination of Plans:**

Brandeis University has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the University shall not have any obligation whatsoever to maintain a Plan for any given length of time. The University, by action of its Board, also may delegate any of its power and duties with respect to the Plan or its amendments to one or more officers or other employees of the University. Any such delegation shall be stated in writing. The University will exercise good faith, apply standards of uniform application, and refrain from arbitrary action.

No vested rights of any nature are provided under the dental plan. Any dental claims or expenses incurred before the date of any plan amendment or termination will be paid in accordance with the plan terms in effect at the time the claim or expense was incurred; provided the claim is filed with the Plan in accordance with the applicable claims procedures and within the applicable time limits for filing such claims.

**No Employment Rights:**

Neither the Plan nor this summary creates an employment contract nor any right to continued employment at Brandeis University.

**Union Agreements:**

The Plan is maintained, in part, pursuant to one or more collective bargaining agreements. You may obtain a copy of the agreements at any reasonable time at the office of the Plan Administrator.

**Support Order Procedures:**

Upon request, copies of the University's procedures for Qualified Medical Child Support Orders (QMCSOs) may be obtained from the Plan Administrator free of charge.

***Denial of Claims:***

If your claim is denied, Delta Dental will provide claimants with a written notification within 90 days of its receipt of such claim. If special circumstances arise and additional time is required, Delta Dental will notify the claimant (within the initial 90 day period), explaining why additional time is needed, and by when they expect to render a final decision. In such an event, Delta Dental will have up to an additional 90 days to decide the claim. Any notice of denial will:

- Set forth the specific reasons for the denial,
- Cite the provisions of the Plan on which the decision is based,
- Describe any additional material or information necessary for the claimant to complete his or her claim and explain why such material or information is necessary,
- Explain the review procedure under the plan.

The claimant or their representative may appeal any denial of a claim within 60 days of receipt of such a denial by submitting a written request for review to Delta Dental. The claimant may also:

- Submit a statement of issues and comments, and
- Request copies, free of charge, or the opportunity to review the plan documents and any other pertinent documents, records or other information relevant to the claim.

Delta Dental will notify the claimant in writing within 60 days of its receipt of the request, unless special circumstances arise and Delta Dental requires additional time. (Upon its notification to the claimant within 60 days, Delta Dental may have up to 60 more days in which to make its final decision.) The notice will specify the reasons for the final decisions and cite the plan provisions on which the decision is based. The notice will also advise the claimant of his or her rights to review or request (free of charge) copies of relevant documents, records and other information, as well as his or her rights under ERISA to bring a civil action with respect to the denial of the claim.

**STATEMENT OF ERISA RIGHTS**

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

**Receive Information About Your Plan and Benefits**

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 furnish each participant with a copy of this summary annual report.

**Prudent Actions by Plan Fiduciaries**

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

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

### **Enforce Your Rights**

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such 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 administrator.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, 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 domestic relations order or 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 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 who has sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.

### **SUMMARY PLAN DESCRIPTION**

The following information, together with the accompanying Benefits and Services Handbook and your group insurance certificate issued to you by United States Life Insurance Company is the Summary Plan Description required by 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:** **Brandeis University Group Life Insurance Plan**

**Plan Number:** **505**

**Plan Sponsor:** **Brandeis University**  
415 South Street  
Waltham, MA 02454-9110

**Plan Administrator:** **Brandeis University**  
Associate Vice President of Human Resources  
and Employee Relations  
415 South Street  
Waltham, MA 02454-9110  
(781) 736-4468

United States Life Insurance Company In the City of New York is granted sole discretionary authority, as Claims Administrator/Insurer, to determine eligibility, make all factual determinations and to construe all terms of the policy/plan. The Plan Sponsor may terminate the policy/plan, or, subject to the United States Life Insurance Company In the City of New York approval, may modify, amend or change the provisions, terms and conditions of the plan. Coverage will also terminate if the premiums are not paid when due. No consent of any Insured or and other person referred to in the policy/plan will be required to terminate, modify, amend or change the policy/plan. See your Plan Administrator to determine what, if any arrangements may be made to continue your coverage beyond the date you cease active work.

**Employer Identification Number:** **04-2103552**

**Agent for Service of Legal Process:** **Brandeis University**  
Associate Vice President of Human Resources  
and Employee Relations  
415 South Street

Waltham, MA 02454-9110  
(781) 736-4468

**Plan Year:**

The financial record of the plan is kept on a contract year basis beginning on each December 1 and ending on each November 30.

**Administration of Group Life Insurance Plan:**

The Plan is administered by the Plan Administrator with benefits provided in accordance with the provision of the applicable group policy issued by United States Life Insurance Company. The Plan is fully-insured. United States Life Insurance Company is solely responsible for financing and providing the benefits under the insurance policies and contracts. The University has no liability for any benefits due, or alleged to be due, under any such insurance policies or contracts.

**Circumstances which may result in disqualification of eligibility, denial, forfeiture or suspension of benefits:**

as set forth in the accompanying Benefits and Service Handbook

**Plan Funding:**

The Plan Sponsor pays the full cost of Basic Life Insurance. Participating employees pay the full cost of Supplemental Life Insurance.

**Amendment and Termination of Plan:**

Brandeis University has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the University shall not have any obligation whatsoever to maintain a Plan for any given length of time. The University, by action of its Board, also may delegate any of its power and duties with respect to the Plan or its amendments to one or more officers or other employees of the University. Any such delegation shall be stated in writing. The University will exercise good faith, apply standards of uniform application, and refrain from arbitrary action.

No vested rights of any nature are provided under the group Life Insurance plan. Any claims or expenses incurred before the date of any plan amendment or termination will be paid in accordance with the plan terms in effect at the time the claim or expense was incurred; provided the claim is filed with the Plan in accordance with the applicable claims procedures and within the applicable time limits for filing such claims.

**No Employment Rights:**

Neither the group term life insurance plan nor this summary create an employment contract nor any right to continued employment at Brandeis University.

**Union Agreements:**

The Plan is maintained, in part, pursuant to one or more collective bargaining agreements. You may obtain a copy of the agreements at any reasonable time at the office of the Plan Administrator.

**Claims Procedure for Life Insurance Claims:**

To file a claim for a benefit, you should send written notice to the Claims Administrator/Insurer. The notice need only identify the claimant and the Policyholder or covered employer. When the Claims Administrator/Insurer receives the notice, they will send a proof of claim form to you. You should receive the proof of claim form within 15 days of the date the Claims Administrator/Insurer received the notice of claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form. Proof of claim must be sent within 180 days of the loss.

If a notice or proof is sent later than the times shown above, the Claims Administrator/Insurer will not deny or reduce a claim if the notice or proof was sent as soon as possible. The maximum time period to submit a proof of claim is one year from the date of the loss.

**Initial Determination:**

The Claims Administrator/Insurer will make an initial determination on life insurance claims within 90 days of receipt of due proof of loss. This period may be extended for up to an additional 90 days if special circumstances require an extension and the Claims Administrator/Insurer notifies you of the extension in writing before the end of the initial 90 day review period.

**Appealing the Initial Determination:**

If your claim for a benefit is denied in whole or in part, you will receive a written explanation of the reason for the denial. On any wholly or partially denied claim, you or your representative may appeal to us for a full and fair review. You have

60 days to file an appeal of a denied claim. You may review pertinent documents and submit issues and comments in writing.

**Notification of Final Claims Decision:**

The Claims Administrator/Insurer will make a final decision no more than 60 days. This period may be extended for up to an additional 60 days if special circumstances (such as the need to hold a hearing) require an extension and the Claims Administrator/Insurer notifies you of the extension in writing before the end of the initial 60 day review period.

If American General denies the claim on appeal, American General will send you a final written decision that includes:

- The specific reasons for the denial;
- Reference the specific plan provision on which the decision is based;
- If an internal rule, guideline, protocol, or other criterion was relied upon in the decision-making, either (1) a copy of the rule, guideline, or protocol or (2) a statement that a copy of the rule, guideline, or protocol will be provided free of charge to the claimant upon written request;
- A statement of claimant’s ERISA rights to bring a civil action with respect to the denial of the claim.

**STATEMENT OF ERISA RIGHTS**

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 and at other specified locations, such as worksites, all Plan documents, including insurance contracts and copies of all documents filed by the Plan administrator with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of Plan documents and any other Plan information upon written request to the Plan Administrator. The Administrator may make reasonable charge for the copies.
- Receive a summary of the plan’s annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan are called “fiduciaries.” They have a duty to operate the Plan prudently and for your interest and for the interest of other Plan participants and the beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way so as to prevent you from obtaining a benefit or exercising your rights under ERISA.

**Enforce Your Rights**

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such 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 administrator.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, 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 domestic relations order or 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 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 who has sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.

### SUMMARY PLAN DESCRIPTION

The following information, together with the accompanying Benefits and Services Handbook and your group insurance certificate issued to you by American General is the Summary Plan Description required by 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:** **Brandeis University Group Long Term Disability Insurance Plan**

**Plan Number:** **508**

**Plan Sponsor:** **Brandeis University**  
415 South Street  
Waltham, MA 02454-9110

**Plan Administrator:** **Brandeis University**  
Associate Vice President of Human Resources  
and Employee Relations  
415 South Street  
Waltham, MA 02454-9110  
(781) 736-4468

The administration of the plan shall be under the supervision of the plan administrator. To the fullest extent permitted by law, the plan administrator shall have the discretion to determine all matters relating to eligibility, coverage and benefits under the plan, and the plan administrator shall have the discretion to determine all matters relating to the interpretation and operation of the plan. Any determination by the plan administrator, or any authorized delegate, shall be final and binding, in the absence of clear and convincing evidence that the plan administrator or delegate acted arbitrarily and capriciously.

Any insurance carrier, as a claim fiduciary, has discretionary authority to construe any and all terms of the group insurance policy it has issued, and the power and discretion to determine questions of fact and law arising in connection with the administration, interpretation and application of the group insurance policy. Any and all of the claims fiduciary's decision with respect to the group insurance policy shall be conclusive and binding on all persons.

**Employer Identification Number:** **04-2103552**

**Agent for Service of Legal Process:** **Brandeis University**  
Associate Vice President of Human Resources  
and Employee Relations  
415 South Street  
Waltham, MA 02454-9110  
(781) 736-4468

**Plan Year:**

The financial record of the plan is kept on a contract year basis beginning on each December 1 and ending on each November 30.

**Administration of Group Long Term Disability Insurance Plan:**

The Plan is administered by the Plan Administrator with benefits provided in accordance with the provision of the applicable group policy issued by American General. The Plan is fully-insured. American General is solely responsible for financing and providing the benefits under the insurance policies and contracts. The University has no liability for any benefits due, or alleged to be due, under any such insurance policies or contracts.

**Circumstances which may result in disqualification of eligibility, denial, forfeiture or suspension of benefits:**

as set forth in the accompanying Benefits and Service Handbook

**Plan Funding:**

The Plan Sponsor pays the full cost of the Long Term Disability Insurance Plan.

**Plan Amendment of Termination:**

Brandeis University has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the University shall not have any obligation whatsoever to maintain a Plan for any given length of time. The University, by action of its Board, also may delegate any of its power and duties with respect to the Plan or its amendments to one or more officers or other employees of the University. Any such delegation shall be stated in writing. The University will exercise good faith, apply standards of uniform application, and refrain from arbitrary action.

No vested rights of any nature are provided under the Long Term Disability plan. Any claims or expenses incurred before the date of any plan amendment or termination will be paid in accordance with the plan terms in effect at the time the claim or expense was incurred; provided the claim is filed with the Plan in accordance with the applicable claims procedures and within the applicable time limits for filing such claims.

**No Employment Rights:**

Neither the group term life insurance plan nor this summary creates an employment contract nor any right to continued employment at Brandeis University.

**Union Agreements:**

The Plan is maintained, in part, pursuant to one or more collective bargaining agreements. You may obtain a copy of the agreements at any reasonable time at the office of the Plan Administrator.

**Claims Procedures for Disability Claims**

To file a claim for a benefit, you should send written notice to the Claims Administrator/Insurer. The notice need only identify the claimant and the Policyholder or covered employer. When the Claims Administrator/Insurer receives the notice, they will send a proof of claim form to you. You should receive the proof of claim form within 15 days of the date the Claims Administrator/Insurer received the notice of claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form. Proof of claim must be sent within 180 days of the loss.

If a notice or proof is sent later than the times shown above, the Claims Administrator/Insurer will not deny or reduce a claim if the notice or proof was sent as soon as possible. The maximum time period to submit a proof of claim is one year.

**Initial Determination:**

The Claims Administrator/Insurer must make initial determination on disability claims within 45 days. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Claims Administrator/Insurer notifies you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. The notice will explain the unresolved issues that prevented a decision on the claim and the additional information needed to resolve those issues.

If your claim is extended due to your failure to submit information necessary to decide your claim, you will be provided at least 45 days from the date of your receipt of the notice within which to provide the required information. The time for making the initial determination will be tolled from the date on which the notification of extension is sent to you until the date we receive your response to our request. The written decision will include specific reasons for the decision, specific references to the plan provisions on which the decision is based, a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary. You will be provided, at your request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim. You will also be provided an explanation of the Plan's appeal review procedure for the type of claim at issue, including applicable time limits and your right to bring a civil action under Section 502(a) of ERISA following a continued denial of a claim after appeal review. If an adverse determination is based on medical necessity or similar exclusion or limitation, an explanation of the scientific or clinical judgment that supports the adverse determination will be provided upon request and free of charge.

**Appealing the Initial Determination:**

If your claim for a benefit is denied in whole or in part, you will receive a written explanation of the reason for the denial. On any wholly or partially denied claim, you or your representative may appeal to us for a full and fair review. You have 180 days to file an appeal of a denial of your claim. You may request, free of charge, copies of all documents, records, and other information relevant to your claim; and submit written comments, documents, records and other information

relating to your claim, and in the case of a plan providing disability benefits, constitute a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant diagnosis without regard to whether such advice or statement was relied upon in making the benefit determination. The review will be conducted by an individual who is neither the person who made the initial review determination nor a subordinate of such person and no deference will be afforded to the initial review determination. If an adverse determination is based on medical judgment, the person conducting the appeal review must consult with a qualified health care professional during the review. If the adverse determination is upheld on appeal review, the Company will provide written notice to you that includes the reason for the adverse determination, the reference to the plan provision on which the decision is based, a statement that you will be provided, free of charge, copies of all information relevant to the claim, copies of any rules, guidelines or protocols used to make the adverse decision, an explanation of the scientific or clinical judgment that supports the decision if such decision is based on medical necessity or a similar exclusion or limitation. You will also be advised of your right to bring a civil action under Section 502(a) of ERISA following a continued denial of a claim after appeal review. You will receive a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information regarding the voluntary appeals procedure. You will also receive a statement indicating that, "You and your Plan may have other voluntary alternate dispute resolution options, such as mediation. For more information you may contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

The Claims Administrator/Insurer will make a decision no more than 60 Days after it receives your appeal. If your appeal is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request. The written decision will include specific references to the plan provision on which the decision is based and any other notice(s), statement(s) or information required by applicable law.

## **STATEMENT OF ERISA RIGHTS**

As a participant in the Group Long Term Disability Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

### **Receive Information About Your Plan and Benefits**

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 furnish each participant with a copy of this summary annual report.

### **Prudent Actions by Plan Fiduciaries**

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

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

### **Enforce Your Rights**

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such 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 administrator.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, 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 domestic relations order or 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 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 who have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

#### **Assistance with Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.

## SUMMARY PLAN DESCRIPTION

The following information, together with the accompanying Benefits and Services Handbook is the Summary Plan Description required by 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:** **Brandeis University Retirement Plan**

**Plan Number:** **001**

**Plan Sponsor:** **Brandeis University**  
415 South Street  
Waltham, MA 02454-9110

**Plan Administrator:** **Brandeis University**  
Associate Vice President of Human Resources  
and Employee Relations  
415 South Street  
Waltham, MA 02454-9110  
(781) 736-4468

The administration of the plan shall be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the plan administrator shall have the discretion to determine all matters relating to eligibility, coverage and benefits under the plan, and the plan administrator shall have the discretion to determine all matters relating to the interpretation and operation of the plan. Any determination by the plan administrator, or any authorized delegate, shall be final and binding, in the absence of clear and convincing evidence that the plan administrator or delegate acted arbitrarily and capriciously.

Any insurance carrier, as a claim fiduciary, has discretionary authority to construe any and all terms of the group insurance policy it has issued, and the power and discretion to determine questions of fact and law arising in connection with the administration, interpretation and application of the group insurance policy. Any and all of the claims fiduciary's decision with respect to the group insurance policy shall be conclusive and binding on all persons.

**Employer Identification Number:** **04-2103552**

**Agent for Service of Legal Process:** **Brandeis University**  
Associate Vice President of Human Resources  
and Employee Relations  
415 South Street  
Waltham, MA 02454-9110  
(781) 736-4468

**Annuity Company:** TIAA-CREF  
730 Third Avenue  
New York, NY 10017  
(212) 490-9000

**Custodian for Custodial Accounts:** Fidelity Management Trust Company  
82 Devonshire Street  
Boston, MA 02109  
(617) 563-7000

**Plan Year:**

The financial record of the plan is kept on a plan year basis beginning on each January 1 and ending on each December 31.

**Administration of Retirement Plan:**

Benefits under the plan are provided by annuity contracts and mutual funds custodial accounts issued to Participants by TIAA-CREF and Fidelity Investments. The University is the Administrator of the Plan and has designated the Associate Vice President for Human Resources and Employee Relations to be responsible for Plan operation. The Plan Administrator is responsible for enrolling participants, forwarding Plan contributions for each participant to the fund sponsors selected, and performing other duties required for operating the Plan. The Plan Administrator has the discretionary authority to interpret and administer the Plan. Subject to the request for review of denied claims described below, the Plan Administrator's decisions are final and binding.

**Circumstances which may result in disqualification of eligibility, denial, forfeiture or suspension of benefits:**

as set forth in the accompanying Benefits and Service Handbook

**Plan Funding:**

Participating employee's pay the full cost of the required employee contributions under the Basic Retirement Plan. The University pays the full cost of the matching University contributions under the Basic Retirement Plan. Participating employees pay the full cost of the Voluntary Retirement Plan.

***Pension Plan Insurance:***

Since the Plan is a defined contribution plan and is established under section 403(b) of the Code, it isn't insured by the PBGC. The PBGC is the government agency that guarantees certain types of benefits under covered plans.

**Non-assignment of Benefits:**

For the protection of you and your beneficiaries, benefits under the plans may not be assigned before receipt and are not subject to garnishment or attachment, except as otherwise required or permitted by law, such as when required by a Qualified Domestic Relations Order (QDRO).

**Investment Responsibility:**

Both the Basic Plan and the Voluntary Plan are intended to constitute plans described in Section 404 (c) of ERISA and Department of Labor Regulations Section 2500.404c-1 with respect to contributions invested at the direction of the Participant. No person, including the University, the Administrator, TIAA-CREF, or Fidelity Investments, shall be liable for any loss or breach of fiduciary duty which is the direct and necessary result of investments instructions given by a Participant or Beneficiary.

**Amendment and Termination of Plan:**

Brandeis University has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the University shall not have any obligation whatsoever to maintain a Plan for any given length of time. The University, by action of its Board, also may delegate any of its power and duties with respect to the Plan or its amendments to one or more officers or other employees of the University. Any such delegation shall be stated in writing. The University will exercise good faith, apply standards of uniform application, and refrain from arbitrary action.

If it is necessary to discontinue the retirement plans, your annuity contracts and custodial accounts under the Basic Retirement Plan is non-forfeitable. Your annuity contracts and custodial accounts under the Voluntary Retirement Plan will remain non-forfeitable. All of these amounts will be used to provide benefits in accordance with the provisions of the Retirement Plan documents. If any material modifications are made in the plans, you will be notified.

**No Employment Rights:**

Neither the Plan nor this summary creates an employment contract nor any right to continued employment at Brandeis University.

**Union Agreements:**

The Plan is maintained, in part, pursuant to on or more collective bargaining agreements. You may obtain a copy of the agreements at any reasonable time at the office of the Plan Administrator.

***Support Order Procedures:***

Upon request, copies of the University's procedures for Qualified Domestic Relations Orders (QDROs) may be obtained from the plan administrator free of charge.

***Retirement Plan Claims Procedures:***

**Filing a Claim for Benefits:**

A claim or request for plan benefits is considered filed when a written communication is made to Brandeis University c/o Associate Vice President for Human Resources and Employee Relations, Mailstop 118, 415 South Street, Waltham, Massachusetts 02254-9110.

**Processing the Claim:**

The Plan Administrator must process the claim within 90 days after the claim is filed. If an extension of time for processing is required, written notice must be given to you before the end of the initial 90 day period. The extension notice must indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render its final decision. In no event can the extension period exceed a period of 90 days from the end of the initial 90 day period.

***Denial of Claim:***

If a claim is wholly or partially denied, the Plan Administrator must notify you within 90 days following receipt of the claim (or 180 days in the case of an extension for special circumstances). The notification must state the specific reason or reasons for the denial, specific references to pertinent plan provisions on which the denial is based, a description of any additional material or information necessary to perfect the claim, and appropriate information about the steps to be taken if you wish to submit the claim for review. If notice of the denial of a claim is not furnished within the 90/180 day period, the claim is considered denied and you must be permitted to proceed to the review stage.

**Review Procedure:**

You or your duly authorized representative has at least 60 days after receipt of a claim denial to appeal the denied claim to an appropriate named fiduciary or individual designated by the fiduciary and to receive a full and fair review of the claim. As part of the review, you must be allowed to review all plan documents and other papers that affect the claim and must be allowed to submit issues and comments and argue against the denial in writing.

***Decision on Review:***

The Plan must conduct the review and decide the appeal within 60 days after the request for review is made. If special circumstances require an extension of time for processing (such as the need to hold a hearing if the plan procedure provides for such a hearing), you must be furnished with written notice of the extension, which can be no later than 120 days after receipt of a request for review. The decision on review must be written in clear and understandable language and must include specific reasons for the decision as well as specific references to the pertinent plan provisions on which the decision is based. If a hearing must be held, the committee can wait to decide until the first meeting after the hearing. However, it must notify you and explain the delay, which can be no later than the third meeting of the committee following the Plan's receipt of the request for review. If the decision on review is not made within the time limits specified above, the appeal will be considered denied. All interpretations, determinations, and decisions of the reviewing entity with respect to any claim will be its sole decision based upon the Plan documents and will be deemed final and conclusive. If appeal is denied, in whole or in part, however, you have a right to file suit in a state or federal court.

STATEMENT OF ERISA RIGHTS

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

**Receive Information About Your Plan and Benefits**

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 furnish each participant with a copy of this summary annual report.
- Obtain a statement telling whether you have a right to receive a pension at normal retirement age and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have the right to a pension, the statement will tell you how many more years you have to work to get a right to a pension.

This statement must be requested in writing and is not required to be given more than once a year. The Plan must provide the statement free of charge.

#### **Prudent Actions by Plan Fiduciaries**

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

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

#### **Enforce Your Rights**

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such 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 administrator.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, 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 domestic relations order or 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 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 who have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

#### **Assistance with Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.

### **SUMMARY PLAN DESCRIPTION**

The following information, together with the accompanying Benefits and Services Handbook is the Summary Plan Description required by 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:** **Brandeis University Flexible Dependent Care Reimbursement Account**

**Plan Number:** **512**

**Plan Sponsor:** **Brandeis University**  
415 South Street

Waltham, MA 02454-9110

**Plan Administrator:** **Brandeis University**  
Associate Vice President of Human Resources  
and Employee Relations  
415 South Street  
Waltham, MA 02454-9110  
(781) 736-4468

The administration of the plan shall be under the supervision of the plan administrator. To the fullest extent permitted by law, the plan administrator shall have the discretion to determine all matters relating to eligibility, coverage and benefits under the plan, and the plan administrator shall have the discretion to determine all matters relating to the interpretation and operation of the plan. Any determination by the plan administrator, or any authorized delegate, shall be final and binding, in the absence of clear and convincing evidence that the plan administrator or delegate acted arbitrarily and capriciously.

**Employer Identification Number:** **04-2103552**

**Agent for Service of Legal Process:** **Brandeis University**  
Associate Vice President of Human Resources  
and Employee Relations  
415 South Street  
Waltham, MA 02454-9110  
(781) 736-4468

**Plan Year:**

The financial record of the plan is kept on a plan year basis beginning on each January 1 and ending on each December 31.

**Administration of Flexible Dependent Care Reimbursement Account Plan:**

The Plan is administered by the Plan Administrator with benefits provided in accordance with the provision of the applicable IRS regulations. Crosby Benefits Systems is the third party administrator.

**Circumstances which may result in disqualification of eligibility, denial, forfeiture or suspension of benefits:**

as set forth in the accompanying Benefits and Service Handbook.

**Plan Funding:**

The Plan is financed by contributions from the participating employees.

**Amendment and Termination of Plans:**

Brandeis University has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the University shall not have any obligation whatsoever to maintain a Plan for any given length of time. The University, by action of its Board, also may delegate any of its power and duties with respect to the Plan or its amendments to one or more officers or other employees of the University. Any such delegation shall be stated in writing. The University will exercise good faith, apply standards of uniform application, and refrain from arbitrary action.

No vested rights of any nature are provided under the Flexible Dependent Care Reimbursement Account Plan. Any claims incurred before the date of any plan amendment or termination will be paid in accordance with the plan terms in effect at the time the claim or expense was incurred; provided the claim is filed with the Plan in accordance with the applicable claims procedures and within the applicable time limits for filing such claims.

**No Employment Rights:**

Neither the Plan nor this summary creates an employment contract nor any right to continued employment at Brandeis University.

***Denial of Claims:***

If you claim is denied, the Plan Administrator will provide claimants with a written notification within 90 days of its receipt of such claim. If special circumstances arise and additional time is required, the Plan Administrator will notify the claimant (within the initial 90 day period), explaining why additional time is needed, and by when the expect to render a final decision. In such an event, the Plan Administrator will have up to an additional 90 days to decide the claim. Any notice of denial will:

- Set forth the specific reasons for the denial,
- Cite the provisions of the Plan on which the decision is based,
- Describe any additional material or information necessary for the claimant to complete his or her claim and explain why such material or information is necessary,
- Explain the review procedure under the plan.

The claimant or their representative may appeal any denial of a claim within 60 days of receipt of such a denial by submitting a written request for review to the Plan Administrator. The claimant may also:

- Submit a statement of issues and comments, and
- Request copies, free of charge, or the opportunity to review the plan documents and any other pertinent documents, records or other information relevant to the claim.

The Plan Administrator will notify the claimant in writing within 60 days of its receipt of the request, unless special circumstances arise and the Plan Administrator requires additional time. (Upon its notification to the claimant within 60 days, the Plan Administrator may have up to 60 more days in which to make its final decision.) The notice of the Plan Administrator will specify the reasons for the final decisions and cite the plan provisions on which the decision is based. The notice will also advise the claimant of his or her rights to review or request (free of charge) copies of relevant documents, records and other information, as well as his or her rights under ERISA to bring a civil action with respect to the denial of the claim.

#### **STATEMENT OF ERISA RIGHTS**

As a participant in the Flexible Dependent Care Reimbursement Account, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

##### **Receive Information About Your Plan and Benefits**

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 furnish each participant with a copy of this summary annual report.

##### **Prudent Actions by Plan Fiduciaries**

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

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

##### **Enforce Your Rights**

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such 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 administrator.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, 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 domestic relations order or 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 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 who have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

#### **Assistance with Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.

## SUMMARY PLAN DESCRIPTION

The following information, together with the accompanying Benefits and Services Handbook is the Summary Plan Description required by 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:** **Brandeis University Flexible Health Care Reimbursement Account**

**Plan Number:** **519**

**Plan Sponsor:** **Brandeis University**  
415 South Street  
Waltham, MA 02454-9110

**Plan Administrator:** **Brandeis University**  
Associate Vice President of Human Resources  
and Employee Relations  
415 South Street  
Waltham, MA 02454-9110  
(781) 736-4468

The administration of the plan shall be under the supervision of the plan administrator. To the fullest extent permitted by law, the plan administrator shall have the discretion to determine all matters relating to eligibility, coverage and benefits under the plan, and the plan administrator shall have the discretion to determine all matters relating to the interpretation and operation of the plan. Any determination by the plan administrator, or any authorized delegate, shall be final and binding, in the absence of clear and convincing evidence that the plan administrator or delegate acted arbitrarily and capriciously.

**Employer Identification Number:** **04-2103552**

**Agent for Service of Legal Process:** **Brandeis University**  
Associate Vice President of Human Resources  
and Employee Relations  
415 South Street  
Waltham, MA 02454-9110  
(781) 736-4468

### **Plan Year:**

The financial record of the plan is kept on a plan year basis beginning on each January 1 and ending on each December 31.

### **Administration of Flexible Dependent Care Spending Account Plan:**

The Plan is administered by the Plan Administrator with benefits provided in accordance with the provision of the applicable IRS regulations. Crosby Benefits Systems is the third party administrator.

**Circumstances which may result in disqualification of eligibility, denial, forfeiture or suspension of benefits:** as set forth in the accompanying Benefits and Service Handbook.

### **Plan Funding:**

The Plan is financed by contributions from the participating employees.

### **Amendment and Termination of Plans:**

Brandeis University has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the University shall not have any obligation whatsoever to maintain a Plan for any given length of time. The University, by action of its Board, also may delegate any of its power and duties with respect to the Plan or its amendments to one or more officers or other employees of the University. Any such delegation shall be stated in writing. The University will exercise good faith, apply standards of uniform application, and refrain from arbitrary action.

No vested rights of any nature are provided under the Flexible Health Care Reimbursement Account Plan. Any claims incurred before the date of any plan amendment or termination will be paid in accordance with the plan terms in effect at the time the claim or expense was incurred; provided the claim is filed with the Plan in accordance with the applicable claims procedures and within the applicable time limits for filing such claims.

**No Employment Rights:**

Neither the Plan nor this summary creates an employment contract nor any right to continued employment at Brandeis University.

***Denial of Claims:***

If you claim is denied, the Plan Administrator will provide claimants with a written notification within 90 days of its receipt of such claim. If special circumstances arise and additional time is required, the Plan Administrator will notify the claimant (within the initial 90 day period), explaining why additional time is needed, and by when the expect to render a final decision. In such an event, the Plan Administrator will have up to an additional 90 days to decide the claim. Any notice of denial will:

- Set forth the specific reasons for the denial,
- Cite the provisions of the Plan on which the decision is based,
- Describe any additional material or information necessary for the claimant to complete his or her claim and explain why such material or information is necessary,
- Explain the review procedure under the plan.

The claimant or their representative may appeal any denial of a claim within 60 days of receipt of such a denial by submitting a written request for review to the Plan Administrator. The claimant may also:

- Submit a statement of issues and comments, and
- Request copies, free of charge, or the opportunity to review the plan documents and any other pertinent documents, records or other information relevant to the claim.

The Plan Administrator will notify the claimant in writing within 60 days of its receipt of the request, unless special circumstances arise and the Plan Administrator requires additional time. (Upon its notification to the claimant within 60 days, the Plan Administrator may have up to 60 more days in which to make its final decision.) The notice of the Plan Administrator will specify the reasons for the final decisions and cite the plan provisions on which the decision is based. The notice will also advise the claimant of his or her rights to review or request (free of charge) copies of relevant documents, records and other information, as well as his or her rights under ERISA to bring a civil action with respect to the denial of the claim.

**STATEMENT OF ERISA RIGHTS**

As a participant in the Flexible Health Care Reimbursement Account, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

**Receive Information About Your Plan and Benefits**

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 furnish each participant with a copy of this summary annual report.

**Prudent Actions by Plan Fiduciaries**

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

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

### **Enforce Your Rights**

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such 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 administrator.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, 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 domestic relations order or 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 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 who have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.

## SUMMARY PLAN DESCRIPTION

The following information, together with the accompanying Benefits and Services Handbook is the Summary Plan Description required by 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:** **Brandeis University Travel Accident Insurance Plan**

**Plan Number:** **510**

**Plan Sponsor:** **Brandeis University**  
415 South Street  
Waltham, MA 02454-9110

**Plan Administrator:** **Brandeis University**  
Associate Vice President of Human Resources  
and Employee Relations  
415 South Street  
Waltham, MA 02454-9110  
(781) 736-4468

The administration of the plan shall be under the supervision of the plan administrator. To the fullest extent permitted by law, the plan administrator shall have the discretion to determine all matters relating to eligibility, coverage and benefits under the plan and the plan administrator shall have the discretion to determine all matters relating to the interpretation and operation of the plan. Any determination by the plan administrator, or any authorized delegate, shall be final and binding, in the absence of clear and convincing evidence that the plan administrator or delegate acted arbitrarily and capriciously.

Any insurance carrier, as a claim fiduciary, has discretionary authority to construe any and all terms of the group insurance policy it has issued, and the power and discretion to determine questions of fact and law arising in connection with the administration, interpretation and application of the group insurance policy. Any and all of the claims fiduciary's decision with respect to the group insurance policy shall be conclusive and binding on all persons.

**Employer Identification Number:04-2103552**

**Agent for Service of Legal Process:** **Brandeis University**  
Associate Vice President of Human Resources  
and Employee Relations  
415 South Street  
Waltham, MA 02454-9110  
(781) 736-4468

### **Plan Year:**

The financial record of the plan is kept on a plan year basis beginning on each January 1 and ending on each December 31.

### **Administration of Group Travel Accident Insurance Plan:**

The Plan is administered by the Plan Administrator with benefits provided in accordance with the provision of the applicable group policies issued by The Hartford Life & Accident Insurance Company, Hartford Plaza, Hartford, Connecticut. The Travel Accident Insurance Plan is fully-insured. The Hartford Life & Accident Insurance Company is solely responsible for financing and providing the benefits under the Travel Accident policy and contract. The University has no liability for any benefits due or alleged to be due, under any such insurance policies or contracts.

**Circumstances which may result in disqualification of eligibility, denial, forfeiture or suspension of benefits:**  
as set forth in the accompanying Benefits and Service Handbook

### **Plan Funding:**

The Plan is financed by contributions from the Plan Sponsor.

### **Amendment and Termination of Plans:**

Brandeis University has established the Plan with the bona fide intention and expectation that it will be continued

indefinitely, but the University shall not have any obligation whatsoever to maintain a Plan for any given length of time. The University, by action of its Board, also may delegate any of its power and duties with respect to the Plan or its amendments to one or more officers or other employees of the University. Any such delegation shall be stated in writing. The University will exercise good faith, apply standards of uniform application, and refrain from arbitrary action.

No vested rights of any nature are provided under the Travel and Accident Insurance. Any claims incurred before the date of any plan amendment or termination will be paid in accordance with the plan terms in effect at the time the claim or expense was incurred; provided the claim is filed with the Plan in accordance with the applicable claims procedures and within the applicable time limits for filing such claims.

**No Employment Rights:**

Neither the Plan nor this summary creates an employment contract nor any right to continued employment at Brandeis University.

**Travel and Accident Plan Claim Procedures:**

The person who has the right to claim benefits (the claimant or beneficiary) must give The Hartford Life & Accident Insurance Company written notice of a claim within 20 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice should include the name of the person who has the right to claim benefits and the policy number.

When The Hartford receives the notice of claim they will send forms to the claimant for giving them proof of loss. The forms will be sent within 15 days after they receive the notice of claim. If the forms are not received, the claimant will satisfy the proof of loss requirement if a written notice of the occurrence, character and nature of the loss is sent to them.

Proof of loss must be sent to The Hartford in writing within 90 days after (1) the end of a period of their liability for periodic payment claims; or (2) the date of the loss for all other claims. If the claimant is not able to send it within that time, it may be sent as soon as reasonable possible without affecting the claim. The additional time allowed cannot exceed one year unless the claimant is legally incapacitated.

***Denial of Claims:***

If you claim is denied, the Plan Administrator will provide claimants with a written notification within 90 days of its receipt of such claim. If special circumstances arise and additional time is required, the Plan Administrator will notify the claimant (within the initial 90 day period), explaining why additional time is needed, and by when the expect to render a final decision. In such an event, the Plan Administrator will have up to an additional 90 days to decide the claim. Any notice of denial will:

- Set forth the specific reasons for the denial,
- Cite the provisions of the Plan on which the decision is based,
- Describe any additional material or information necessary for the claimant to complete his or her claim and explain why such material or information is necessary,
- Explain the review procedure under the plan.

The claimant or their representative may appeal any denial of a claim within 60 days of receipt of such a denial by submitting a written request for review to the Plan Administrator. The claimant may also:

- Submit a statement of issues and comments, and
- Request copies, free of charge, or the opportunity to review the plan documents and any other pertinent documents, records or other information relevant to the claim.

The Hartford will notify the claimant in writing within 60 days of its receipt of the request for review, unless special circumstances (such as the need to hold a hearing), but in no case more than 120 days after The Hartford receives the request for review. The written decision will include specific reasons for the decision on which the decision is based. The notice will also advise the claimant of his or her rights to review or request (free of charge) copies of relevant documents, records and other information, as well as his or her rights under ERISA to bring a civil action with respect to the denial of the claim.

**STATEMENT OF ERISA RIGHTS**

As a participant in the Group Travel Accident Insurance Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

### **Receive Information About Your Plan and Benefits**

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 furnish each participant with a copy of this summary annual report.

### **Prudent Actions by Plan Fiduciaries**

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

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

### **Enforce Your Rights**

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such 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 administrator.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, 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 domestic relations order or 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 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 who have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.

## SUMMARY PLAN DESCRIPTION

The following information, together with the accompanying Benefits and Services Handbook is the Summary Plan Description required by 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:** Brandeis University Educational Assistance Plan

**Plan Number:** 518

**Plan Sponsor:** Brandeis University  
415 South Street  
Waltham, MA 02454-9110

**Plan Administrator:** Brandeis University  
Associate Vice President of Human Resources  
and Employee Relations  
415 South Street  
Waltham, MA 02454-9110  
(781) 736-4468

The administration of the plan shall be under the supervision of the plan administrator. To the fullest extent permitted by law, the plan administrator shall have the discretion to determine all matters relating to eligibility, coverage and benefits under the plan and the plan administrator shall have the discretion to determine all matters relating to the interpretation and operation of the plan. Any determination by the plan administrator, or any authorized delegate, shall be final and binding, in the absence of clear and convincing evidence that the plan administrator or delegate acted arbitrarily and capriciously.

**Employer Identification Number:** 04-2103552

**Agent for Service of Legal Process:** Brandeis University  
Associate Vice President of Human Resources  
and Employee Relations  
415 South Street  
Waltham, MA 02454-9110  
(781) 736-4468

### **Plan Year:**

The financial record of the plan is kept on a plan year basis beginning on each January 1 and ending on each December 31.

### **Administration of Educational Assistance Plan:**

The Plan is administered by the Plan Administrator with benefits provided as set forth in the accompanying Benefits and Services Handbook.

### **Plan Funding:**

The Plan is financed by contributions from the Plan Sponsor.

**Circumstances which may result in disqualification of eligibility, denial, forfeiture or suspension of benefits:**  
as set forth in the accompanying Benefits and Service Handbook.

### **Amendment and Termination of Plans:**

Brandeis University has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the University shall not have any obligation whatsoever to maintain a Plan for any given length of time. The University, by action of its Board, also may delegate any of its power and duties with respect to the Plan or its amendments to one or more officers or other employees of the University. Any such delegation shall be stated in writing. The University will exercise good faith, apply standards of uniform application, and refrain from arbitrary action.

No vested rights of any nature are provided under the Flexible Dependent Care Spending Account Plan. Any claims incurred before the date of any plan amendment or termination will be paid in accordance with the plan terms in effect at the time the claim or expense was incurred; provided the claim is filed with the Plan in accordance with the applicable claims procedures and within the applicable time limits for filing such claims.

**No Employment Rights:**

Neither the Plan nor this summary creates an employment contract nor any right to continued employment at Brandeis University.

***Denial of Claims:***

If you believe you are being denied any rights or benefits under the Plan, you may file a written claim with the Plan Administrator. The Plan Administrator will provide claimants with a written notification within 90 days of its receipt of such claim. If special circumstances arise and additional time is required, the Plan Administrator will notify the claimant (within the initial 90 day period), explaining why additional time is needed, and by when they expect to render a final decision. In such an event, the Plan Administrator will have up to an additional 90 days to decide the claim. Any notice of denial will:

- Set forth the specific reasons for the denial,
- Cite the provisions of the Plan on which the decision is based,
- Describe any additional material or information necessary for the claimant to complete his or her claim and explain why such material or information is necessary,
- Explain the review procedure under the plan.

The claimant or their representative may appeal any denial of a claim within 60 days of receipt of such a denial by submitting a written request for review to the Plan Administrator. The claimant may also:

- Submit a statement of issues and comments, and
- Request copies, free of charge, or the opportunity to review the plan documents and any other pertinent documents, records or other information relevant to the claim.

The Plan Administrator will notify the claimant in writing within 60 days of its receipt of the request, unless special circumstances arise and the Plan Administrator requires additional time. (Upon its notification to the claimant within 60 days, the Plan Administrator may have up to 60 more days in which to make its final decision.) The notice of the Plan Administrator will specify the reasons for the final decisions and cite the plan provisions on which the decision is based. The notice will also advise the claimant of his or her rights to review or request (free of charge) copies of relevant documents, records and other information, as well as his or her rights under ERISA to bring a civil action with respect to the denial of the claim.

**STATEMENT OF ERISA RIGHTS**

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

**Receive Information About Your Plan and Benefits**

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 furnish each participant with a copy of this summary annual report.

**Prudent Actions by Plan Fiduciaries**

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

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

### **Enforce Your Rights**

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such 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 administrator.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, 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 domestic relations order or 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 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 who have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.