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INTRODUCTION

The fringe benefit program at Brandeis University helps to provide the means by which Postdoctoral Fellows/Research Associates and Visiting Scholars can obtain health and dental coverage for themselves and their families. Participation in the Brandeis University Voluntary Retirement Plan is also available.

The contents of this handbook are informational only. Neither the plan nor this summary creates an employment contract nor any right to continued employment at Brandeis University. Information described on this handbook are not meant to change the benefit plans or any legal instrument related to the creation, operation, funding or benefit payment obligations of the benefit plans.

If there is any conflict or inconsistency between the handbook and the plan documents constituting each benefit plan, or if any provision of a benefit plan is not discussed, the plan documents constituting the benefit plan will govern. Brandeis University reserves the right to modify, revoke, suspend, terminate or change any and all such plans, benefits, policies and procedures at any time it deems necessary, with or without notice.
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 EPO Plan
- Tufts Premium EPO Plan
- Tufts PPO Plan

HMO Plans
An EPO 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.

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

Summary of Benefits
A Summary of Benefits and Coverage (SBC) outlines basic coverage and co-payments for each plan and can be found on the Human Resources website www.brandeis.edu/humanresources. The Health Insurance Plan Comparison Chart in this handbook and on the Human Resources website provides a brief one page overview of covered services that are available under each plan. Both are designed to help you select the plan best suited to your needs. Insurance Plan enrollment kits describing the health insurance coverage are available in the Benefits section of the Office of Human Resources. Enrollment forms can be found on the Human Resources website under "Forms". Upon enrollment, Tufts EPO participants will receive a "Description of Benefits 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
If your appointment at Brandeis University is for a period of six months or more and you will be receiving salary through the University Payroll Office, you may enroll in one of our health insurance programs and will receive a University contribution toward the cost of the monthly premiums.

If your appointment at Brandeis University is for a period of six months or more, but no funds will be paid directly from the University, you may enroll in one of the health insurance programs but you must assume 100% of the monthly premiums.
If your appointment at Brandeis University is for a period of **less than six months**, you are not eligible to participate in any of the University health insurance programs.

In general, your "dependents" may be eligible for coverage under the University’s medical insurance. Eligible dependents include your:

- Spouse
- Ex-spouse.
  - If you and your spouse divorce or legally separate, your former spouse may continue coverage as a dependent under your family coverage in accordance with Massachusetts law (documentation is required).
  
  Note: If you remarry, your former spouse’s coverage as a dependent under your family coverage will end. However, your former spouse may continue coverage under an individual policy. If your former spouse remarries, coverage will end unless continuation is still available under federal law.

- Children. The term “children” includes the following individuals until their 26th birthday:
  - your or your spouse’s natural child, stepchild, or legally adoptive child; or
  - the child of your natural child, stepchild, or legally adoptive child;
  - any other child for whom you have legal guardianship; or
  - any other child who meets the IRS Code definition of your dependent or your spouse’s dependent
  - A child who is over age 26 and resides with you or your spouse and became permanently physically or mentally disabled before age 26 and is incapable of supporting himself or herself due to a disability.

Refer to your Subscriber Certificate for more information. See the COBRA section of this handbook regarding option to continue coverage following the termination of dependent status.

**Enrollment**

Newly hired postdoctoral fellows/research associates and visiting scholars must complete a Tufts Health Plan member enrollment form and submit it to the Benefits section of the Office of Human Resources within 31 days of their hire date. Member Enrollment Forms are available in the Benefits section of the Office of Human Resources. After the initial eligibility period has passed, eligible employees 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**

(Qqualifying 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 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;
5. Covered dependent reaches the age limit for coverage making him or her ineligible for coverage;
6. You, your spouse or eligible dependent moves out of or into your medical plan's service area.
7. You, your spouse 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 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 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 or eligible dependent, provided that either (a) the election change made by your spouse 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 or eligible dependent's employer does not correspond with the University calendar year plan year.

Special Enrollment Rights – Children's Health Insurance Program (CHIP)
Effective April 1, 2009, employees and their dependents who are eligible but not enrolled in our medical plan have Special Enrollment Rights:

1. The employee's or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility and the employee requests coverage under the plan within 60 days after the termination
2. The employee or dependent become eligible for a premium assistance subsidy under Medicaid or CHIP, and the employee requests coverage under the plan within 60 days after eligibility is determined.
**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 will announce the open enrollment period each year.

**Provider Directories/Physician Listings**
The electronic physician directory for choosing a Primary Care Physician (PCP) may be accessed via the Human Resources website or the Tufts website at [www.tuftshealthplan.com](http://www.tuftshealthplan.com). 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. Paper copies will be made available and may be requested from the Benefits section of the Office of Human Resources free of charge.

**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.

**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
- Prostheses 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.
Genetic Information Nondiscrimination Act of 2008 (GINA)
The Genetic Information Nondiscrimination Act of 2008 (GINA) protects individuals against discrimination based on their genetic information when enrolled in a group health plan.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. MHPAEA supplements prior provisions under the Mental Health Parity Act of 1996 (MHPA), which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits.

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.
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Tufts HMO/EPO Value (1)</th>
<th>Tufts HMO/EPO Premium (1)</th>
<th>Tufts PPO In-Network Benefit</th>
<th>Out-of-Network [after deductible] (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Physicals (7)</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Doctor Office Visits</td>
<td>$25 / visit</td>
<td>$25 / visit</td>
<td>$25 / visit</td>
<td></td>
</tr>
<tr>
<td>Hospitalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room &amp; Board (4)</td>
<td>$250 / admission</td>
<td>Covered in full</td>
<td>$250 / admission</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Physician/Surgeon Services</td>
<td>Covered in full after copay</td>
<td>Covered in full</td>
<td>Covered in full after copay</td>
<td></td>
</tr>
<tr>
<td>Day Surgery</td>
<td>$100 / surgery</td>
<td>Covered in full</td>
<td>$100 / surgery</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Assisted Reproductive Technology</td>
<td>$100 / surgery</td>
<td>Covered in full</td>
<td>$25 / surgery</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>High Tech Imaging</td>
<td>$75 / visit</td>
<td>$75 / visit</td>
<td>$75 / visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Maternity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal/Postnatal Care (routine)</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>$250 / admission</td>
<td>Covered in full</td>
<td>$250 / admission</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Out of Pocket Maximum</td>
<td>$2,500 for single (1)</td>
<td>$1,250 for single (1)</td>
<td>$2,500 for single (2)</td>
<td>$5,000 for single (2)</td>
</tr>
<tr>
<td>Mental Health &amp; Substance Abuse <strong>Inpatient – Biological (4)</strong></td>
<td>$250 / admission</td>
<td>Covered in full</td>
<td>$250 / admission</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>• Mental Health</td>
<td>$25 / visit</td>
<td>$25 / visit</td>
<td>$25 / visit</td>
<td></td>
</tr>
<tr>
<td>• Substance Abuse</td>
<td>$25 / visit</td>
<td>$25 / visit</td>
<td>$25 / visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Outpatient – Non-Biological</td>
<td>$25 / visit</td>
<td>$25 / visit</td>
<td>$25 / visit</td>
<td>20% coinsance</td>
</tr>
<tr>
<td>• Mental Health</td>
<td>$25 / visit</td>
<td>$25 / visit</td>
<td>$25 / visit</td>
<td>20% coinsance</td>
</tr>
<tr>
<td>• Substance Abuse</td>
<td>$25 / visit</td>
<td>$25 / visit</td>
<td>$25 / visit</td>
<td>20% coinsance</td>
</tr>
<tr>
<td>Physical Therapy (short-term physical, occupational and speech therapy)</td>
<td>$25 / visit</td>
<td>$25 / visit</td>
<td>$25 / visit</td>
<td>20% coinsance</td>
</tr>
<tr>
<td>Emergency Care (3)(5)</td>
<td>$100 / visit</td>
<td>$100 / visit</td>
<td>$100 / visit</td>
<td>$100 / visit</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>$25 / visit, up to 20 visits per calendar year</td>
<td>$25 / visit, up to 20 visits per calendar year</td>
<td>$25 / visit, up to 20 visits per calendar year</td>
<td>20% coinsurance, up to 20 visits/ calendar year</td>
</tr>
<tr>
<td>Prescription Drugs (up to a 30 day supply)</td>
<td>$15, Tier I</td>
<td>$15, Tier I</td>
<td>$15, Tier I</td>
<td></td>
</tr>
<tr>
<td>Mail Order Rx Drugs (up to a 90 day supply)</td>
<td>$30, Tier II</td>
<td>$30, Tier II</td>
<td>$30, Tier II</td>
<td></td>
</tr>
<tr>
<td>Weight Management &amp; Fitness Reimbursement (8)</td>
<td>$150 weight management &amp; $150 fitness reimbursement per calendar year</td>
<td>$150 weight management &amp; $150 fitness reimbursement per calendar year</td>
<td>$150 weight management &amp; $150 fitness reimbursement per calendar year</td>
<td></td>
</tr>
</tbody>
</table>

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

**Terms and Conditions**

1. The HMO/EPO Value plan includes an out of pocket maximum of $2,500 for an individual and $5,000 for a family per calendar year and the HMO/EPO Premium plan includes an out of pocket maximum of $1,250 for an individual and $2,500 for a family per calendar year. All copayments (including prescription drug copayments) count towards this maximum.

2. All covered Out-of-Network PPO benefits are paid at 80% after satisfying $500 deductible for single plans and a $1,000 deductible for family plans. The PPO plan out of pocket maximum for out of network services is $2,500 individual / $5,000 family per calendar year. There is a separate out of pocket maximum on in network services of $2,500 individual / $5,000 family per calendar year. Deductibles, coinsurance and copayments (including prescription drug copayments) count towards the out of pocket maximum.

3. Waived if immediately admitted to the hospital. If admitted to an in-network hospital, a $250 Inpatient copayment would apply on both the HMO/EPO Value and PPO plans. Members would be responsible for 20% coinsurance on the PPO plan if admitted to an out-of-network hospital.

4. A semi-private room is provided unless a private room is medically necessary.

5. If you receive outpatient Emergency care at an emergency facility, you or someone acting on your behalf should call your PCP (HMO/EPO) 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. 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.

7. Cost sharing has been removed on preventive services as follows: Routine physical exams (including most preventive screenings), Well-Child Care, Preventive Immunizations, Preventive Pap Smears, Preventive Mammograms & Routine Colonoscopies (Colonoscopies which include any surgical removal will not be considered preventive, and will be subject to the copay, deductible and/or coinsurance).

8. The Weight Management reimbursement (up to $150 per family per year) and the Fitness Reimbursement (up to $150 per family per year) is available by submitting a reimbursement form to Tufts HP.

9. A maximum of two copayments apply per member per calendar year.

10/23/15 for CY2016
DENTAL INSURANCE

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

- Delta Dental PPO Plus Premier Plan (Indemnity Dental Plan)
- DeltaCare DMO (Dental Maintenance Organization)

Delta Premier Dental Plan
Delta PPO Plus Premier 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. Delta Dental PPO Plus Premier Plan also provides coverage for services received from dentists who don’t participate in the Delta Premier 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 on the Office of Human Resources website www.brandeis.edu/humanresources. 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. The Subscriber Certificate is a legal document governing matters pertaining to the dental insurance program.

Eligibility
If your appointment at Brandeis University is for a period of six months or more and you will be receiving salary through the University Payroll Office, you may enroll in one of our dental insurance programs and will receive a University contribution toward the cost of the monthly premiums.

If your appointment at Brandeis University is for a period of six months or more, but no funds will be paid directly from the University, you may enroll in one of the dental insurance programs but you must assume 100% of the monthly premiums.

If your appointment at Brandeis University is for a period of less than six months, you are not eligible to participate in any of the University dental insurance programs.

In general, your “dependents” may be eligible for coverage under the University’s medical insurance. Eligible dependents include your:

- Spouse
- Ex-spouse.
  - If you and your spouse divorce or legally separate, your former spouse may continue coverage as a dependent under your family coverage in accordance with Massachusetts law (documentation is required).
Note: If you remarry, your former spouse’s coverage as a dependent under your family coverage will end. However, your former spouse may continue coverage under an individual policy. If your former spouse remarries, coverage will end unless continuation is still available under federal law.

- Children. The term “children” includes the following individuals until their 26th birthday:
  - your or your spouse’s natural child, stepchild, or legally adoptive child; or
  - the child of your natural child, stepchild, or legally adoptive child;
  - any other child for whom you have legal guardianship; or
  - any other child who meets the IRS Code definition of your dependent or your spouse’s dependent
  - A child who is over age 26 and resides with you or your spouse and became permanently physically or mentally disabled before age 26 and is incapable of supporting himself or herself due to a disability.

Refer to your Subscriber Certificate for more information. See the COBRA section of this handbook regarding option to continue coverage following the termination of dependent status.

Enrollment
Newly hired postdoctoral fellows/research associates and visiting scholars must complete a Delta Dental enrollment form and submit it to the Benefits section of the Office of Human Resources within 31 days of their hire date. Member Enrollment Forms are available in the Benefits section of the Office of Human Resources. After the initial eligibility period has passed, eligible employees 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 Human Resources 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;
5. Covered dependent reaches the age limit for coverage making him or her ineligible for coverage;
6. You, your spouse 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 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 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, 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 or eligible dependent’s employer does not correspond with the University’ calendar year plan year.

**Effective Date of Change in Status**

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 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 will announce the open enrollment period each year.

**Provider Directories**

The provider directory for the Delta Dental PPO plus Premier Plan can be found at [www.deltadentalma.com](http://www.deltadentalma.com) utilizing both the Delta Premier and Delta PPO networks. The provider directory for the DeltaCare Plan can be found at [www.deltadentalma.com](http://www.deltadentalma.com) utilizing the DeltaCare USA network. Paper copies will be made available and may be requested from the Benefits section of the Office of Human Resources free of charge.

**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.

**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. 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 dental 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

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

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, 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 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 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, 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 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 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 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 a 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 premiums 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 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 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.

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

Brandeis University 781-736-4468
Vice President for Human Resources
Office of Human Resources – MS 118
PO Box 549110
Waltham, MA 02454-9110
VOLUNTARY RETIREMENT PLAN

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. [http://www1.tiaa-cref.org/tcm/brandeis/enrollnow/index.htm](http://www1.tiaa-cref.org/tcm/brandeis/enrollnow/index.htm)

- **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. [http://www1.tiaa-cref.org/tcm/brandeis/enrollnow/index.htm](http://www1.tiaa-cref.org/tcm/brandeis/enrollnow/index.htm)

- **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. [www.netbenefits.com/brandeis](http://www.netbenefits.com/brandeis)

The University is the administrator of the Plan and has designated the 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.

Employee Voluntary Contributions to The Plan

The following Summary Plan Description summarizes the “Plan” for employee voluntary contributions:

Eligibility for Employee Voluntary Contributions
Eligible employee means all regular faculty, staff, Postdoctoral Fellows/Research Associates, and Visiting Scholars who are paid by Brandeis University with the exception of an employee whose primary association with Brandeis is as a student; a temporary employee; or a leased employee (within the meaning of Code section 414(n)).

Participation Begins
If you are an eligible employee, you may, on a voluntary basis begin participation in this Plan on the first day of any month that coincides with or follows your date of hire. If you are reemployed by the University, you will be eligible to participate in the Plan on the first day of any month that coincides with or follows your date of hire as an eligible employee.

To participate in the Plan, an eligible employee must complete a Salary Reduction Agreement form indicating how much you want to contribute, either as a percentage of pay or per paycheck amount. If you elect a percentage of pay, that percentage will be deducted from each subsequent paycheck. This form also authorizes Brandeis to remit those contributions to your selected investment provider(s). Your voluntary
contributions cannot reduce your salary to the degree that there is not enough remaining pay to support taxes, pre-tax benefits, or regular recurring deductions.

In addition, you must complete the appropriate investment provider enrollment form (TIAA-CREF or Fidelity Investments or both) indicating your investment choices and designation of beneficiaries. All forms need to be returned to the Benefits section of the Office of Human Resources. 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.

**Participation Ends**
Your participation in the Plan ends when you are no longer employed by Brandeis, elect to discontinue contributions to the Plan or are no longer eligible to participate. If you are a former employee who is reemployed as an eligible employee, you may re-establish contributions to the Plan by signing a Salary Reduction Agreement form, and if necessary, an investment provider enrollment application.

**Voluntary Employee Contributions**
Participants determine the percentage of their compensation they wish to contribute to the Plan. These contributions are made on a pre-tax basis. This means that the money you contribute to the Plan is deducted from your salary before taxes are withheld from your compensation. Taxes are also deferred on any investment gains or losses that accumulate in the Plan. Although your Plan contributions reduce your pay for income tax purposes, pay-related Brandeis benefits, such as retirement, life insurance coverage and long-term disability insurance are not affected.

**Limits:** The IRS currently limits how much a participant may contribute on a pre-tax basis to a retirement plan(s). Generally, the maximum combined employee contribution (required and voluntary) to the Plan may not exceed $18,000 for calendar year 2016. However, if you are or will be at least age 50 during the calendar year, you may contribute an additional amount up $6,000 for calendar year 2016 for a total of $24,000. Contributions to an individual's other tax-deferred retirement account may also impact these limits (e.g. 401(K), Keogh Plan). It is your responsibility to notify the Benefits section of the Office of Human Resources if you are contributing to another retirement account. You should also consult with your own tax advisor to avoid exceeding the contribution limits and possible related tax penalties.

In addition to the limits federal laws apply to the dollar amount that may be contributed; others laws 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.

**How to Change the Rate of Voluntary Contributions or Stop Voluntary Contributions to the Plan**
A participant may make a change in the percentage contributed or suspend voluntary contributions to the Plan the first of any month by submitting a Salary Reduction Agreement form to the Benefits section of the Office of Human Resources. The form must be submitted the month prior to the effective date of the Salary Reduction Agreement form. You may change the rate of contribution or stop the contribution amount once each calendar quarter.

**Note:** Participants who also contribute the required employee contributions to the Plan cannot stop or change the required contributions and the required contributions shall remain in effect until the employee is no longer eligible to participate in the Plan or the Plan is terminated.

**Contributions While on an Approved 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 or while receiving workers compensation benefits.
You may elect to suspend your voluntary contributions during a paid leave of absence by completing a Salary Reduction Agreement form and submitting it to the Benefits section of the Office of Human Resources.

**Contributions While on Active Duty in the Armed Forces**
No contributions will be made during an unpaid military leave however Participants will be allowed to make-up retirement contributions missed during active service. Participants must make-up the contributions within a period not exceeding three times the period of military service but, in no case, may the period exceed 5 years.

**Rollover Contributions**
You may consolidate retirement funds from previous employers provided retirement plans are transferred to your voluntary account. An eligible employee who is entitled to receive an eligible rollover distribution from another eligible retirement plan may request to have all or a portion of the eligible rollover distribution paid to the Plan on his or her behalf. An eligible retirement plan means an individual retirement account described in Section 408(A) of the Code, an individual retirement annuity described in Section 408(b) of the Code, a qualified trust described in Section 401(a) of the code, an annuity plan described in Section 403(a) or 403(b) of the code, or an eligible governmental plan described in Section 457(b) of the Code. Such rollover contributions shall be made in the form of cash only. All rollovers contributions to the Plan are subject to the terms of the Plan. If you wish to roll over your accounts to the Plan, you must complete the necessary investment provider forms and you should contact the investment provider that currently holds these funds to determine if they require additional forms. For more information about rollover contributions, please contact the Benefits section of the Office of Human Resources.

**Investment Options**
The Plan offers a variety of investment options available through our retirement vendors, TIAA-CREF and Fidelity Investments. You are able to direct the investment of your voluntary contributions to TIAA-CREF Group Supplemental Retirement Contract and/or Fidelity Investments Custodial Accounts.

You can select a mix of investment options that best suits your goals, time horizon and risk tolerance. The various investment options available through the Plan include conservative, moderately conservative and aggressive investment options. You may split your contributions between providers in increments of 10% equaling 100%. Investment options elected with each vendor must also equal 100%.

Contributions may be invested in one or a combination of the investment options.

* **Tier 1: Lifecycle Funds (available only through Fidelity Investments)**
The Plan offers a blend of stocks, bonds and short-term investments within a single fund. The lifecycle funds have an asset allocation based on the number of years until the fund’s target retirement date. Lifecycle funds are designed for investors expecting to retire around the year indicated in each fund’s name. The investment risk of each lifecycle fund changes over time as each fund’s asset allocation changes.

* **Tier 2: Core Funds (available only through Fidelity Investments)**
Core funds are designed for people who want to take a more hands-on approach and select their own investment mix from a choice of individual investment options. The mutual funds available on our Fidelity Investment platform are both Fidelity funds and other investment companies’ funds. You may choose from a range of mutual fund choices that reflect different styles and goals, ranging from least aggressive to most aggressive.

* **Tier 3: Annuities (available only through TIAA-CREF)**
Fixed and Variable Annuities. The TIAA Traditional Annuity, a guaranteed annuity account guarantees your principal and a contractually specified interest rate. Variable annuities are insurance contracts (that invest in stocks and bonds and short term investments) in which, at the end of the accumulation stage, the insurance company guarantees a minimum payment.
Descriptions of all of the investment fund options available through the investment providers are included in your enrollment packet provided to you by the Benefits section of the Office of Human Resources.

Once you have decided how to allocate your contributions between the investment providers, you must then decide how to allocate contributions within each investment provider's fund offerings. If you fail to submit your selected provider enrollment form(s) prior to the submission of your contributions to your selected provider your contributions will be invested in a “default” fund. Currently, the “default fund is the appropriate Vanguard Target Retirement Fund based on your date of birth. You may change your allocation of contributions between TIAA-CREF and Fidelity Investment four times in a calendar year.

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. The Plan Administrator may add or eliminate investments options at any time in its discretion.

**Investment Responsibility**

The Plan is intended to constitute plans described in Section 404 (c) of Employee Retirement Income Security Act, and Title 29 of the Code of Federal Regulations, Section 2500.404c-1. This means the Plan lets you choose from a broad range of investments, and you can and have the responsibility to decide for yourself how to invest the assets in your Retirement Plan account(s).

Section 404(c) provides that no person, including the University, the Administrator, the plan fiduciaries, 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 you, your beneficiaries, or an alternate payee. It is important that you learn about the various investments options before deciding how to allocate your contributions.

No one at the University is authorized to give investment advice with respect to the Plan. If you have questions about investing, you should consult a professional financial advisor. The Benefits section of the Human Resources Office or the investment providers can help you collect information that might assist you in making your decision.

Before selecting your fund allocation, you should carefully evaluate all of your investment options available within the Plan. To balance your risk and return you should diversify your investments. This means that you should spread your retirement savings among different types of investments and assets classes, such as stocks, bonds, guaranteed annuities, and short-term investments. Investing in several types of investment option can help you balance your risk and potential returns.

**Fees**

All investment options sponsored by the investment providers pay a management fee for management of a fund’s investments and related expenses. The fee reduces the overall return earned by the investment option. Returns are reported net of management fees. All fees are described in the investment option prospectus.

**How to Change Your Investment Provider for Future and Past Contributions**

You may change your investment provider for future contributions by submitting a completed Salary Reduction Agreement form indicating a change in investment carrier to the Benefits section of the Office of Human Resources. If a participant has not previously opened a voluntary contract with the investment company, an enrollment application must also be completed. You may change your allocation of contributions between TIAA-CREF and Fidelity Investment four times a calendar year.

You may change the way your past contributions are invested, by contacting the investment provider directly and requesting a Transfer form from the investment company to which the participant is moving the funds. Transfers of past contributions are permitted to the extent allowed by the terms of the investment provider’s contracts.
Note that you may not transfer your voluntary contribution Plan assets to the employee/university match contribution Plan assets or your employee/university match contribution Plan assets to your voluntary Plan assets.

**How to Change Your Fund Allocation or Transfer Funds Within an Investment Provider**

You may change your fund allocation with an investment provider anytime by contacting them directly.

You may transfer fund assets to another fund within the same provider by contacting them directly.

Note that redemption of shares within 90 days in some Fidelity funds may have a redemption fee deducted from your account by Fidelity. Contact Fidelity for more information regarding these fees.

A transfer out of the TIAA Real Estate Account is limited to one per calendar quarter.

**Vesting**

Employee voluntary contributions shall be fully vested and non-forfeitable when such Plan contributions are made. Being vested means you have a right to the value of your Plan account (e.g. your contributions adjusted for investment gains and losses) when you leave the University or in certain other circumstances.

**Loans**

The Plan does allow participants to borrow money attributable to employee voluntary contributions and rollover contributions invested in TIAA-CREF. The Plan does not allow participants to borrow money that is invested with Fidelity Investments however participants may transfer their voluntary/rollover contributions from Fidelity to TIAA-CREF if they are interested in taking a loan from the Plan. Participants interested in borrowing from their account, should contact TIAA-CREF directly to ensure that they are familiar with all terms of the loan provisions and to request the application forms. If married, spousal consent is required for a loan distribution.

Generally, IRS rules limit the amount that can be borrowed from the Plan to the lesser of one-half of your account balance, or $50,000 (reduced by the highest outstanding loan balance during the 12 months preceding the loan). The loan will bear a reasonable rate of interest and will be secured by your voluntary/rollover Plan assets. You will be required to make regular payments and (except in the case of a loan used to acquire a principal residence) the loan is repayable within five years. Contact TIAA-CREF for more information.

**In-Service Withdrawals**

In general, withdrawals by a participant from his or her Plan are not permitted while he or she is still an employee of the University.

**Withdrawals After Age 59 ½**

If you have reached age 59 ½, you may request a withdrawal from your account. Any such withdrawal will be subject to the terms of the investment options to which you have allocated contributions. You must obtain spousal consent in order to make such withdrawals.

**Hardship Withdrawals**

If you incur a hardship before you terminate employment, you may withdraw any amount attributable to your own voluntary contributions made on a salary reduction basis (other than income/earnings allocated after December 31, 1988), 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 severe financial need and the distribution is necessary to meet the financial need. To be considered for a hardship distribution, you'll need to complete a “Brandeis University Request for Hardship Withdrawal” application form and supply supporting documentation required by the Plan administrator (form available from the Benefits section of the Office of Human Resources). In addition, you will need to complete a distribution form from the investment provider (contact the investment provider for the required form). Note that nontaxable loans currently available
under the Plan and all other Plans maintained by the university must have been made prior to your request for a hardship withdrawal.

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; beginning with the pay period after the hardship withdrawal is approved. 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.

All hardship withdrawals are subject to spousal consent rules. Hardship withdrawals prior to age 59 ½ are subject to ordinary income tax plus a 10% early withdrawal penalty tax, unless the withdrawal is for unreimbursed medical expenses that exceed 7.5% of your adjusted gross income.

Participants who are interested in a hardship withdrawal should contact the Benefits section of the Office of Human Resources for assistance.

To the extent provided in an Annuity Contract or Custodial Account, a Participant may withdraw funds in order to satisfy an immediate and severe financial need arising from:

- uninsured medical expenses described in IRS Publications 502 (as in effect for the year of withdrawal) incurred by the Participant his or her spouse, designated beneficiary, or any of his or her dependents (as defined in Code section 152 as modified for purposes of Code sections 105 and 106);
- costs directly related to the purchase of a principal residence of the Participant (excluding mortgage payments);
- the payment of tuition and related education fees and room and board expenses for the next 12 months of post-secondary education for the Participant, his or her spouse, designated beneficiary, children or dependents (as defined in Code section 152 as modified for purposes of Code section 401(k) or 401(m));
- payments necessary to prevent the eviction of the Participant from his or her principal residence or foreclosure on the mortgage on the principal residence;
- payments for burial or funeral expenses for the Participant’s deceased parent, spouse, designated beneficiary, children or dependents (as defined in Code section 152 as modified for purposes of Code sections 105 and 106);
- expenses for the repair of damage to the Participant’s principal residence that would qualify for a casualty deduction under Code Section 165 (without regard to whether the loss exceeds 10% of the Participant’s adjusted gross income).

Participation in a Phased Retirement Program
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 “Withdrawals Upon Termination of Employment or Retirement” will apply.

Withdrawals Upon Termination of Employment or Retirement
All withdrawals are initiated by contacting the Investment Provider(s) directly.

Termination of Employment
Subject to the rights of your spouse to survivor benefits, you may elect partial or full withdrawal of your Plan account after termination of employment. Any such withdrawals will be subject to the terms of the investment options to which you have allocated contributions.
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.

How Your Account Will Be Paid
When you become eligible for a distribution, you may have the value of your account paid as annuity, a lump sum payment, or in installment payments. You have the right to choose an income option subject to your spouse's right (under federal pension law) to survivor benefits, unless this right is waived by you and your spouse.

Single Participants
If you are not married on the date your benefit is to begin under the Plan, your retirement benefits will be paid to you in the form of a Single Life Annuity (no survivor benefits are payable after your death).

Married Participants
Participants who are married when retirement benefit payments begin are required by Federal Law to use the 50% Joint and Survivor Annuity Option. Federal law requires that continuing payments to a surviving spouse (does not apply to spousal equivalents) must be at least 50% of the monthly payment made to the participant during his/her retirement. In the event that no such percentage is specified, the percentage shall be 50%.

Optional Forms of Payments
If you wish to waive the single life annuity or the qualified joint and survivor annuity (as applicable), you may elect to have the value of your account distributed in any other form of benefit available under an Annuity Contract or Custodial Account. Married participant and their spouses may waive the spousal entitlement only if a written waiver is filed with the investment provider. This waiver can only be signed if the participant is age 35 or older and must be signed by the participant and the spouse. The spouse’s signature must be witnessed by a Notary Public or a Brandeis University Benefits Administrator.

The following optional forms of payment are available from TIAA-CREF:

Lifetime Annuity 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 any time. 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).

Interest Only Payments- 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.

The following optional forms of payment are available from 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.
Distributions After Death
If a participant dies before the distribution of benefits has begun, the participant’s 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.

Single Participants – A participant who dies prior to his or her annuity starting date and is not married on the date of death, amounts held in an annuity contract or custodial account for his or her benefit will be paid to the beneficiary designated by the participant in accordance with the terms of such annuity contract or custodial account (or, where no such beneficiary is designated, the participant’s estate). Distribution will be made in the form or forms provided in such annuity contract or custodial account.

Married Participants – 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. In addition, see “Spousal Rights to Survivor Benefits” below.

Spousal Rights 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. Consent to an alternative form of benefit must either specify a specific form or expressly permit designation by you without further consent.

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.

Qualified Domestic Relations Order (QDRO)
A QDRO is a court order made under a state’s domestic relations law related to the provision of property rights, alimony, or child support to a spouse (or former spouse), child, or the dependent of a participant.

To be considered a QDRO it must create or recognize the existence of an alternate payee’s right to receive all or a portion of a participant’s benefit and specify each plan to which the order applies. The QDRO must also include the name and last known mailing address of the participant; the name and last known mailing address of the alternate payee; amount or percent of the participant’s benefits to be paid to the alternate payee or how the amount or percentage must be determined, number of payments or period to which the order applies.

The QDRO cannot require the Plan to provide any benefit type, form or option not otherwise provided under the Plan, additional vesting, additional benefits, or benefit payments to an alternate payee that are already required to be paid to another alternate payee under a prior QDRO.

If you should receive a Domestic Relations Order (DRO) and your retirement plan contributions are invested with TIAA-CREF then you should forward the DRO to TIAA-CREF for processing. If your retirement plan contributions are invested with Fidelity Investment you should forward the DRO to the Benefits section of the Office of Human Resources. Upon receipt of the DRO, the Plan Administrator will send a written Notice of Receipt of the DRO to the participant and alternate payee to indicate that the Plan Administrator is in receipt of the DRO and is in the process of reviewing it and to permit an alternate payee to designate a representative to receive copies of all notices. The Plan Administrator will review the DRO to ensure it meets all the qualifications for a QDRO. The Plan Administrator will then send a Notice of Status of Domestic Relations Order notifying the appropriate parties whether the DRO is a QDRO. If the DRO does not meet the criteria of a QDRO, the Plan Administrator will indicate which criteria it does not meet. A QDRO will be forwarded to Fidelity for processing.

Beneficiary Designations
A participant will designate their beneficiary for the Plan on the investment provider(s) enrollment application. Your primary beneficiary is the person(s) to whom benefits will be paid in the event of your death.

If you are married at the time of your death, your beneficiary will automatically be your surviving spouse unless your spouse has previously consented to the payment of your account to another beneficiary you have named. Refer to the section entitled “Spousal Rights to Survival Benefits” for more information.

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

If you do not designate a beneficiary your account will go to your surviving spouse (if any), otherwise to your estate.
Rollover Distributions
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.

Applying for a Distribution
When you become eligible to receive a distribution, call your investment provider to request a distribution form and instructions. All distributions must be approved by a benefits representative from the University. The investment provider will instruct you if the forms need to be signed by a benefits representative. Once your distribution is approved, your Voluntary Retirement Plan account will be distributed according to your election.

Taxation of Voluntary Retirement Plan Distributions
Distributions received from your account are subject to federal and state ordinary income tax as you receive payments because your contributions to the Plan were made on a pre-tax basis and the interest earnings and or investment gains and losses on your contributions were not taxed while they were accumulating in your account. However, for Massachusetts tax purposes, contributions, which were made prior to January 1, 1998, are considered after tax contributions. All contributions subsequent to January 1, 1998 are pre-tax and subject to taxes upon withdrawal. All distributions from the Plan will be taxed in the year you receive payment.

Federal law requires the investment provider(s) to withhold income taxes from benefit payments, unless you instruct them to do otherwise (withholding may be mandatory under certain circumstances). Federal income tax will be withheld from the amount of any lump sum payment made to you or your surviving spouse from the Plan at a rate of 20%, unless the distribution is transferred directly to an IRA account or another qualifying employer sponsored account. Annuity payments and distributions to a beneficiary other than your spouse may not be rolled into an IRA or another qualifying employer sponsored account, but will be subject to 10% federal income tax withholding (unless your beneficiary, as applicable, elect to have no federal income tax withheld).

Besides normal federal income taxes, an additional 10% tax applies to benefits received before age 59½ (age 55 or later, if you terminate employment after reaching that age). This penalty will not apply if the distribution is:

- paid because of death or disability;
- used to pay for unreimbursed medical expenses that are greater than 7.5% of your adjusted gross income;
- paid to a non-participant under a Qualified Domestic Relations Order (10% penalty taxable to the recipient, rather than the participant);
- rolled over into an IRA or another employer’s eligible retirement plan.

Federal tax rules are complicated and subject to change. This description is only a summary. Consult with your personal accountant or tax advisor before making a withdrawal or taking a distribution from the Plan.
ACTIVITIES AND SERVICES

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. The Card Office hours of operation are 9:00 to 4:30 Monday through Friday.

Athletic and Recreational Activities
Employees are welcome to utilize the facilities of the Gosman Sports and Convocation Center. To do so, your ID card is required. Employees 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. Information about performances and exhibits may be found at http://www.brandeis.edu/arts/.

- Brandeis Tickets is a centralized on-campus box office operated by Brandeis staff and students. They provide ticket services for Student Activities, the Brandeis Concert Series, Brandeis Theater Company, Student Events, Undergraduate Theatre Collective, and various university clubs and organizations, as well as special events performed at Brandeis University. You may order tickets on-line at the site or call: 781-736-3400.

Parking Privileges
All employees 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 Box Office
The Office of Human Resources provides discount or free admission tickets to movie theaters and museums. The Box Office is open Monday through Friday from 9:00 to 5:00 in the Office of Human Resources. Payment must be made by check or money order only. All employees must show their ID. For more information visit the Human Resources website at www.brandeis.edu/humanresources or call (781) 736-4474.

- 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 are available for the following movie theaters: AMC, Showcase and Landmark.
- Museum of Science: Discount tickets for museum admittance available. 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. Please note that special exhibits are not included in the general admission.
- New England Aquarium: Discount tickets for the aquarium are available. This represents a substantial savings on adult admission. Please note that special exhibits are not included in the general admission.

Tickets, passes or information on any of these programs are available in the Office of Human Resources at Bernstein-Marcus.

**On Campus ATMs**
As a convenience to employees, in the Shapiro Campus Center, there is a Citizens Bank ATM. There is also a Santander 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 at the Office of Human Resources website.

**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**
Your paycheck must be deposited directly into a checking and/or saving account. You can set-up the process through BUSS or contact the Payroll Office, [payroll@brandeis.edu](mailto:payroll@brandeis.edu) with any questions.

**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. Employees are invited to participate.

**University Facilities**
If you are interested in using a University facility for a personal occasion, you may make arrangements through Conference and Events at [http://www.brandeis.edu/ces or x64300](http://www.brandeis.edu/ces).

**Employee Assistance Program**
All employees are eligible for free confidential legal, family and financial counseling through LifeScope. [www.LifeScopeEAP.com](http://www.LifeScopeEAP.com)
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
Vice President of Human Resources
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
Vice President for Human Resources
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, 705 Mt. Auburn St. Watertown MA, 02471 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 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 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 months 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
Vice President for Human Resources
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
Vice President of Human Resources 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 Delta PPO Plus Premier 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 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 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 for Faculty, Professional, and Administrative Staff (001) Non-Exempt Employees (002)

Plan Number: 001 and 002

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

Plan Administrator: Brandeis University
Vice President for the Office of Human Resources
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
Vice President for Human Resources
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 Vice President for Human Resources 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:
The Plan is currently funded solely by contributions by participants based upon their voluntary elections. All contributions are invested in annuity contracts or mutual fund custodial accounts issued or maintained by the Investments Providers. Investments are directed by each Plan participant with respect to his or her account.

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:
The Voluntary Retirement Plan is intended to constitute plan 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 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 the Vice President for Human Resources, 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.

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