

BRANDEIS UNIVERSITY

BENEFITS AND SERVICES

FOR

FACULTY MEMBERS

OFFICE OF HUMAN RESOURCES
SEPTEMBER, 2014

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INTRODUCTION

The goal of the fringe-benefit program at Brandeis University is to provide faculty with a core set of benefits that will provide them with options to adequately meet their needs and the needs of their families. The University currently offers health and dental insurance, life and disability insurance plans, flexible reimbursement accounts, and a basic and voluntary retirement plans as core benefits to eligible faculty. In addition to these core benefits, the University provides additional benefits, services and activities to help enhance the quality of life.

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

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

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

If you elect to enroll in one of the health insurance plans Tufts Health Insurance will send you detailed information regarding the plan you selected. If you elect to enroll in one of the dental insurance plan a subscriber certificate will be sent to you via campus mail. Individual life and long term disability insurance contracts are sent to each participant after enrollment via campus mail. This handbook, together with the booklets, certificates, and other descriptive materials you receive from the University and the benefit plan vendors, constitute the summary plan description (SPD) for individuals who are currently eligible for benefits. All of the University's benefit plans are governed by formal plan documents. The SPD is not meant to change the benefit plans or any legal instrument related to the creation, operation, funding, or benefit payment obligations of the benefit plans. If there is any conflict or inconsistency between the SPD and the plan documents constituting each benefit plan, or if any provision of a benefit plan is not discussed in the SPD, the Plan documents constituting the benefit plan will govern.

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 in 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.

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

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

MEDICAL INSURANCE

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

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

HMO Plans

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

PPO Plan

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

Faculty Residing Beyond the Tufts HMO Service Area

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

Summary of Benefits

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. 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 HMO participants will receive an "Evidence of Coverage Handbook" and Tufts PPO participants will receive a "Certificate of Insurance Handbook" detailing the provisions of the program, an identification card and other relevant material from the insurance carrier. The Evidence of Coverage Handbook and the Certificate of Insurance Handbook are the legal documents governing all matters pertaining to the health insurance program.

Eligibility

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

In general, your "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 (dependent verification is required).

Refer to your Tufts Evidence of Coverage or Tufts Certificate of Insurance handbooks for more information.

Enrollment

Newly hired faculty members must complete a Tufts Health Plan member enrollment form and submit it to the Benefits section of the Office of Human Resources 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 faculty and their eligible dependents may choose to enroll during any subsequent open enrollment period or within 31 days after a qualifying event or other permissible event occurs to the participant (subscriber) or to his or her dependent.

Coverage Effective Date

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

Change in Status

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

IRS regulations under Section 125 of the Internal Revenue Code require that once you have made your pre-tax election for coverage, you may not change them during the plan year unless you have a qualifying change in status or other permissible event. If you request an election change, it must be on account of and correspond with the change in status. If you experience a change in status, or other permissible event, you must contact the Benefits section of the Office of 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, annulment, termination of a same-sex domestic partner relationship;
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.

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. 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
- Prosthesis and physical complications at all stages of the mastectomy, including lymph edemas.

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

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, or
- the date you or your dependents fail to pay for the cost of coverage, or
- 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.

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

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. A coverage certificate provides you with evidence of your coverage under the medical plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have medical problems. If you elect COBRA continuation coverage, you will also receive a coverage certificate after COBRA coverage ends. Keep a copy of the coverage certificate(s) you receive, as you may need to prove you had prior coverage if you join a new plan sponsored by another employer or enroll in an individual health insurance plan. You and/or your dependents, or someone on your behalf, may also request a coverage certificate within 24 months of the date your University coverage ended. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 month (18 months for late enrollees) after your enrollment date in your new coverage.

Continuation of Group Health Plan Coverage

You may be able to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. Review the COBRA section of this handbook and your Tufts Evidence of Coverage or Tufts Certificate of Insurance handbook on the rules governing your COBRA continuation rights. You

may also be eligible to convert your University group health plan to an individual non-group policy within 31 days following your last day of coverage. Contact Tufts Health Plan for more information.

Health Insurance Continuation for Certain Faculty Terminating at Age 62

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

Covered Services	Tufts Value HMO/EPO (1)	Tufts Premium HMO/EPO (1)	Tufts PPO	
			In-Network Benefit	Out-of-Network (after deductible) (2)
Outpatient Care Routine Physicals (7) Doctor Office Visits	Covered in full \$25 / visit	Covered in full \$20 / visit	Covered in full \$25 / visit	20% coinsurance 20% coinsurance
Hospitalization Room & Board (4) Physician/Surgeon Services	\$250 / admission Covered in full after copay Covered in full after copay	Covered in full Covered in full Covered in full	\$250 / admission Covered in full after copay Covered in full after copay	20% coinsurance 20% coinsurance (6) 20% coinsurance
Day Surgery Routine Colonoscopy (7)	\$100 / surgery Covered in full	Covered in full Covered in full	\$100 / surgery Covered in full	20% coinsurance 20% coinsurance
Assisted Reproductive Technology High Tech Imaging	\$100 / surgery \$75 / visit (9)	Covered in full \$75 / visit (9)	\$100 / surgery \$75 / visit (9)	20% coinsurance 20% coinsurance
Maternity Routine Prenatal/Postnatal Care Hospitalization	Covered in full \$250 / admission	Covered in full Covered in full	Covered in full \$250 / admission	20% coinsurance 20% coinsurance
Out of Pocket Maximum	\$2,500 for single (1) \$5,000 for family (1)	\$1,250 for single (1) \$2,500 for family (1)	\$2,500 for single (2) \$5,000 for family (2)	\$2,500 for single (2) \$5,000 for family (2)
Mental Health & Substance Abuse Inpatient – Non-Biological (4) • Mental Health • Substance Abuse	\$250 / admission \$250 / admission	Covered in full Covered in full	\$250 / admission \$250 / admission	20% coinsurance 20% coinsurance
Outpatient – Non-Biological • Mental Health • Substance Abuse	\$25 / visit \$25 / visit	\$20 / visit \$20 / visit	\$25 / visit \$25 / visit	20% coinsurance 20% coinsurance
Physical Therapy (short-term physical, occupational and speech therapy)	\$25 / visit	\$20 / visit	\$25 / visit	20% coinsurance
Emergency Care (3)(5)	\$100 / visit	\$100 / visit	\$100 / visit	\$100 / visit
Chiropractic Care	\$25 / visit, up to 20 visits per calendar year	\$20 / visit, up to 20 visits per calendar year	\$25 / visit, up to 20 visits per calendar year	20% coinsurance, up to 20 visits/ calendar year
Prescription Drugs (up to a 30 day supply)	\$15, Tier I \$30, Tier II \$50, Tier III	\$15, Tier I \$30, Tier II \$50, Tier III	\$15, Tier I \$30, Tier II \$50, Tier III	
Mail Order Rx Drugs (up to a 90 day supply)	\$30, Tier I \$60, Tier II \$150, Tier III	\$30, Tier I \$60, Tier II \$150, Tier III	\$30, Tier I \$60, Tier II \$150, Tier III	
Weight Management & Fitness Reimbursement (8)	\$150 weight management & \$150 fitness reimbursement per calendar year	\$150 weight management & \$150 fitness reimbursement per calendar year	\$150 weight management & \$150 fitness reimbursement per calendar year	

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

Terms and Conditions

- The Value HMO/EPO plan includes an out of pocket maximum of \$2,500 for an individual and \$5,000 for a family per calendar year and the Premium HMO/EPO 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.
- 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.
- Waived if immediately admitted to the hospital. If admitted to an in-network hospital, a \$250 Inpatient copayment would apply on both the Value HMO/EPO and PPO plans. Members would be responsible for 20% coinsurance on the PPO plan if admitted to an out-of-network hospital.
- A semi-private room is provided unless a private room is medically necessary.
- If you receive outpatient Emergency care at an emergency facility, you or someone acting on your behalf should call your PCP (HMO) or Tufts HP within 48 hours after receiving care. You are encouraged to contact your Primary Care Physician so your PCP can provide or arrange for any follow-up care that you may need.
- 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.
- 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).
- 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 Health Plan.
- A maximum of two copayments apply per member per calendar year.

DENTAL INSURANCE

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

- DeltaDental PPO *plus* Premier Plan (Indemnity Dental Plan)
- DeltaCare DMO (Dental Maintenance Organization)

DeltaDental PPO plus Premier Plan

Delta Dental 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 DeltaPremier network. However, your out-of-pocket expenses may be more. Delta Dental's payments for services received from non-participating dentists are based on either the dentist's fee or the maximum plan allowance for the non-participating dentists, whichever is lower. If you utilize the services of a non-participating dentist whose fees are higher than the maximum plan allowance, you will be responsible for the difference between Delta Dental's payment and the dentist's total submitted charges. Please refer to your subscriber certificate for more information.

DeltaCare -Dental Maintenance Organization (DMO)

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

Summary of Benefits

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

Eligibility

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

In general, your "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 faculty members 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 faculty and their eligible dependents may choose to enroll during any subsequent open enrollment period or within 31 days after a qualifying event or other permissible event occurs to the participant (subscriber) or to his or her dependent.

Coverage Effective Date

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

Change in Status

(Qualifying Events/Other Permissible Event)

IRS regulations under Section 125 of the Internal Revenue Code require that once you have made your pre-tax election for coverage, you may not change them during the plan year unless you have a qualifying change in status or other permissible event. If you request an election change, it must be on account of and correspond with the change in status. If you experience a change in status, or other permissible event, you must contact the Benefits section of the Office of 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 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.

Effective Date of Change in Status

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

Changing Plans – Open Enrollment

The opportunity to switch from one plan to another, to join for the first time, or to add dependents without a qualifying event, is available for a two week period each November with an effective date of January 1. The Benefits section of the Office of Human Resources 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 utilizing both the *Delta Premier* and *Delta PPO* networks. The provider directory for the DeltaCare Plan can be found at 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 are no longer in an eligible class for group health coverage under the plan, or
- the date you or your dependents fail to pay for the cost of coverage, or

- 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.

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

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) required group health plans to protect the confidentiality of your private health information. The privacy provisions of HIPAA will apply to the University's Medical and Dental Insurance Plan and the Health Care Reimbursement Account Plan.

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

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

The Plans will maintain a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact the Benefits section of the Office of Human Resources. If you have questions about the privacy of your health information, please contact the Benefits section of the Office of Human Resources or the University's designated privacy official.

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 or you are participating in the Flex Health Care Reimbursement Account, you have a right to choose this continuation coverage if you lose your group health or dental coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

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

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

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

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

Under the law, the employee or a family member has the responsibility to inform Brandeis University, Office of Human Resources, 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 beneficiary not receiving continuation coverage (such as fraud).

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

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

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

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

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

Please contact the Benefits section of the Office of Human Resources 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
Assistant Vice President for Human Resources
Mail Stop 118
415 South Street
Waltham, MA 02454
(781) 736-4468

GROUP TERM LIFE INSURANCE

Benefit Overview

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

Eligibility

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

Basic Coverage

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

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

Supplemental Coverage

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

Age Schedule	\$20,000	\$50,000	\$100,000	\$200,000
Under 30	\$1.00	\$2.50	\$5.00	\$10.00
30 - 34	\$1.40	\$3.50	\$7.00	\$14.00
35 - 39	\$1.80	\$4.50	\$9.00	\$18.00
40 - 44	\$2.00	\$5.00	\$10.00	\$20.00
45 - 49	\$3.00	\$7.50	\$15.00	\$30.00
50 - 54	\$4.60	\$11.50	\$23.00	\$46.00
55 - 59	\$8.60	\$21.50	\$43.00	\$86.00
60 - 64	\$15.20	\$38.00	\$76.00	\$152.00
65 - 69	\$25.40	\$63.50	\$127.00	\$254.00

Supplemental Insurance for Employees 70 and Over

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

Age Schedule	\$10,000	\$25,000	\$50,000	\$100,000
70 - 74	\$21.60	\$54.00	\$108.00	\$216.00
75 and over	\$27.20	\$68.00	\$136.00	\$272.00

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

Insurance Certificate

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

Group Life Insurance Taxation

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

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

Waiver of Premium

If an employee becomes totally disabled while insured and it is before age 65, life insurance continues during the disability for 12 months after cessation of premium payments. If the employee furnishes proof that such disability has been continuous for at least six months before the end of the twelve-month period, the insurance will continue as long as the employee remains disabled. This is subject to the employee submitting proof of continued disability at such intervals as the insurance company may reasonably require. In the event of death during the insurance continuance period, proof must be furnished to the insurance company, within one year following the date of death that the disability had existed uninterrupted until the date of death.

Designating Beneficiaries

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

Termination of Employment

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

Conversion and Portability Privilege

Within the 31 days following the end of the month of your termination of employment, you have two options to keep your coverage. Conversion allows you to convert all or part of your current term life insurance under the Group Policy to an individual whole life policy. Portability allows you to take all or part of your current term life insurance under the Group Policy in term insurance. These policies will be issued on the basis of your attained age and will not require medical examination. Please refer to your certificate issued by the insurance company for more information. The insurance company must receive your completed application and a check for the full first premium payment within 31 days of your date of termination of insurance.

Accidental Death and Dismemberment Insurance (AD&D)

Your basic life insurance coverage (excludes supplemental life insurance) also includes an Accidental Death and Dismemberment insurance benefit. Refer to the life insurance certificate provided by the insurance company for more information.

GROUP LONG-TERM TOTAL DISABILITY INSURANCE

Benefit Overview

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

Eligibility

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

Definition of Total Disability

Total disability under this program is the inability of the employee, by reason of physical disease, injury, pregnancy or mental disorder, to perform with reasonable continuity the material duties of your own occupation.

Benefits Coverage

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

Monthly Income Benefit: is the amount equal to 60% of the first \$25,000 of monthly base salary of your predisability earnings, reduced by deductible income, to a \$15,000 monthly maximum. This includes any income benefits payable from Social Security and Workers Compensation (refer to you insurance certificate for more information regarding deductible income). In no event will the Disability Insurance Monthly Income Benefit be less than \$100.00, even though this amount plus Social Security and Workers Compensation Benefits may bring you total income to more than 60% of salary.

Monthly Basic Retirement Plan Contribution Benefit:

For employees who are under age 50 or have attained age 50 but have not yet qualified for the additional 2% University contribution toward the basic retirement plan, the amount of the monthly annuity premium benefit cannot exceed 13% of your eligible predisability earnings. For employees who are age 50 and over and are receiving the additional 2% University contribution toward the basic retirement plan, the monthly annuity premium benefit will be 15% of your eligible predisability earnings.

Insurance Certificate

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

Termination of Insurance Coverage

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

Maximum Benefit Period

Attained Age	Duration of Benefits
61 or younger	To age 65, or 3 years 6 months, if longer.
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

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

Retirement Plan

Benefit Overview

The “Brandeis University Defined Contribution Retirement Plan for Faculty, Professional, and Administrative Employees” allows employees to tax-defer contributions out of their Brandeis University compensation to save for retirement. Effective January 1, 2009 the University merged the “Basic Plan” which consists of required employee contributions and the Brandeis match with the “Tax Deferred Annuity Plan” which consists of employee voluntary contributions.

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

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

The University is the administrator of the Plan and has designated the Vice President for Human Resources 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, Post Doctoral 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 \$17,500 for calendar year 2014. However, if you are or will be at least age 50 during the calendar year, you may contribute an additional amount up to \$5,500 for calendar year 2014 for a total of \$23,000. 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 invests 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

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 anytime. Systematic cash withdrawals are not available from TIAA Traditional Retirement Annuity.

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

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

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.

Employee Required Contributions and University Match

The following Summary Plan Description summarizes the "Plan" for the required employee contribution and the University Match:

Eligibility

All Faculty with a full-time equivalent appointment of 50% or greater and who has attained age 21 (revised 7/1/05) and has fulfilled the year of service requirement. A year of service is defined under the next section "Participation Begins".

All Professional and Administrative employees (except Post Doctoral Fellows/Research Associates, Visiting Scholars, a leased employee (within the meaning of Code section 414(N)), a temporary employee or an employee whose primary association with Brandeis is as a student) scheduled to work 17 1/2 hours or more in a position that is normally scheduled for a 35 hour work week for at least 39 weeks per year or scheduled to work 20 hours or more in a position that is normally scheduled for a 40 hour work week for at least 39 weeks per year; and who has attained age 21 (revised 7/1/05) and has fulfilled the year of service requirement. A year of service is defined under the next section "Participation Begins".

Participation Begins

If you are an eligible employee, you may, on a voluntary basis begin participation in this Plan on the first day of the month that follows one year of benefits eligible service at the University. All eligible faculty and staff must initiate the process to enroll in the Plan.

Waiver

This service requirement is waived for employees who were employed for at least one year in a half-time or more position at a higher education institution immediately preceding the employee's date of employment at Brandeis (up to three months lapse in time between prior employment and Brandeis employment is allowed). Service with such higher education institution will be treated as service with Brandeis for purposes of the one-year of service requirement. Your former employer must complete a "Service Credit at Other College or University" form.

Reemployment

A former employee who is reemployed by the University will be eligible to participate upon meeting the eligibility requirements as stated above. A former employee who satisfied these requirements before termination of employment will be eligible to begin participation immediately after reemployment provided the former employee is an eligible employee.

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 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. An employee who has been notified that he or she is eligible to participate but who fails to return the enrollment forms will be deemed to have waived all of his or her rights under the Plan except the right to enroll at a future date.

Notification

The University will notify an eligible employee when he or she has completed the requirements necessary to become a Participant. An eligible employee who is reemployed with the University must initiate enrollment or reenrollment in the Plan.

An eligible employee who complies with the requirements and becomes a Participant is entitled to the benefits and is bound by all the terms, provisions, and conditions of the Plan, including any amendments that, from time to time, may be adopted, and including the terms, provisions and conditions of any Funding Vehicle(s) to which Plan Contributions for the Participant have been applied.

Plan Contributions (Required Employee Contributions and University Match)

When you begin participation in the Plan, contributions will be made automatically to the funding vehicles that you have chosen at TIAA-CREF or Fidelity. The contributions are based on a percentage of your eligible compensation, according to the schedule shown below. University Plan contributions will only be made for participants who are making the required participant plan contributions. Participant plan contributions will be deducted from salary payments or, if elected by the participant, will be made pursuant to a salary reduction agreement on a tax-deferred basis in accordance with the requirements of Code Section 403(b) and the regulations hereunder. Under the salary reduction agreement, the employee's salary (paid after the agreement is signed) is reduced and the amount of the reduction is applied as premiums to the Funding Vehicles available under this Plan. An election to make the required participant plan contributions may not be made retroactively.

Important Note: Once an election is made to participate in the Plan a participant cannot stop 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.

Plan Contributions as a Percentage of Eligible Compensation

Participant's Attained Age	Employee Required Contribution	University Contribution
Under Age 50	5%	8%
On September 1 st , following age 50 and one year of service	5%	10%

Eligible compensation for any period means the base salary or wages paid by the University to a Participant during the period (including, for faculty, contractual or summer salary and compensation for additional courses taught or supplemental pay for acting as department chairperson) excluding, for example overtime, one-time increases, bonuses, and any non-cash remuneration. Compensation taken into account under the Plan cannot exceed the limits of IRC Section 401(a)(17). The limit under Section 401(a)(17) is currently \$260,000 effective January 1, 2014. The limit is adjusted from time to time by the Secretary of the Treasury.

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 \$17,500 for calendar year 2014. However, if you are or will be at least age 50 during the calendar year, you may contribute an additional amount up \$5,500 for calendar year 2014 for a total of \$23,000. 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.

Contributions While on an Approved Leave of Absence

During a paid leave of absence, Plan contributions will continue to be made based on your eligible compensation paid during your leave of absence. No contributions will be made during an unpaid leave of absence or while receiving workers compensation benefits.

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.

Contributions While Receiving Long Term Disability Benefits

Contributions will be made to the Plan on your behalf if you receive benefits under the Brandeis University Long Term Disability Plan. The long term disability insurance carrier will continue to remit

the employee required contribution (5%) and the University match (8% or 10%) subject to applicable legal limitation. The amount of such contributions shall be based on your eligible compensation immediately before you became disabled.

For more information, please refer to the Long Term Disability Plan Document.

Rollover Contributions

You may consolidate retirement funds from previous employers provided retirement plans are transferred to an employee voluntary Plan 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.

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.

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 invests 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.

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 collection information that might assist you in making your decision.

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 in 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 required contributions and the University match 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 not allow participants to borrow money that is invested in the TIAA-CREF Retirement Account or Fidelity Investments.

The Plan does allow participants to borrow money attributable to employee voluntary contributions and rollover contributions invested in TIAA-CREF (refer to the Summary Plan Description for employee voluntary contributions).

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.

Hardship Withdrawals

If you incur a hardship before you terminate employment, you may withdraw any amount attributable to your own contributions (both required and voluntary) 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

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 anytime. Systematic cash withdrawals are not available from TIAA Traditional Retirement Annuity.

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

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

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.

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 Retirement Plan account will be distributed according to your election.

Taxation of 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, employee voluntary contributions (excludes required 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.

FLEXIBLE DEPENDENT CARE REIMBURSEMENT ACCOUNT

Benefit Overview

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

Flexible Dependent Care Reimbursement Account

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

Eligible Dependents

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

Eligible Dependent Care Expenses

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

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

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

Contribution Limits

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

- Actual costs;
- The earned income of the lower paid spouse;

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

Forfeiture of Contributions

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

Eligibility

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

Enrollment

Eligible employees may enroll within 31 days from their date of hire or appointment, or within 31 days of when you first receive your benefits information, whichever is later. If you do not enroll when you first become eligible for the plan, you may enroll during the annual open enrollment period (usually held in November) for the Plan Year beginning January 1. A Plan Year is defined as the calendar year. In addition, you may be able to enroll in the Plan outside the open enrollment period if you experience a change in your life that has an impact on your benefits.

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

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

Change in Amount Deducted

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

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

IRS regulations under Section 125 of the Internal Revenue Code require that once you have made your pre-tax election for coverage, you may not change them during the plan year unless you have a qualifying change in status or other permissible event. If you request an election change, it must be on account of and correspond with the change in status. If you experience a change in status, or other permissible event, you must contact the Benefits section of the Office of Human Resources 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. The termination or commencement of employment of your spouse, the switching from part-time to full-time (or vice versa) by you or your spouse;
5. You, your spouse, or eligible dependent begins or returns from an unpaid leave of absence; or
6. Such other events that the Administrator determines will permit the revocation of an election (and, if applicable, the filing of a new election) during a plan year under regulations and rulings of the Internal Revenue Service.

Other Permissible Events

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

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

Effective Date of Change in Status

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

Plan Administrator Adjustments to Your Deposits

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

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

Non-Discrimination Compliance Changes by Plan Administrator

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

End of Employee Deposits

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

No such reimbursement shall exceed the remaining balance, if any, in your Flexible Dependent Care Reimbursement Account for the Plan year in which expenses were incurred.

If you die during a plan year, your spouse (or, if none, your executor or administrator) may be reimbursed from your unused account balances for eligible expenses as permitted by the plan. Claims must be submitted within 120 days of your death.

Forfeited Deposits

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

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

Effects on Your Salary

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

Claims Procedures

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

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

Submit the reimbursement form(s) with supporting documentation directly to one of the following:

Reimbursement Portal: www.MyCrosbyBenefits.com

Email: servicecenter@crosbybenefits.com

Fax: 978-367-9626

Mail: Crosby Benefit Systems

PO Box 25172
Lehigh Valley, PA 18002-5172

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

Deadline to Submit Claims

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

Reimbursement of Claims

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

FLEXIBLE HEALTH CARE REIMBURSEMENT ACCOUNT

Benefit Overview

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

Flexible Health Care Reimbursement Account

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

Eligible Health Care Expenses

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

- Deductibles, coinsurance and co-payments under your medical and/or dental insurance plan;
- Eyeglasses, contact lenses and necessary supplies;
- Dental expenses (other than cosmetic) not covered or not paid in full by insurance;
- Laser vision or eye correction surgery.

Expenses not covered by Health Care Reimbursement Accounts:

- Medical and dental premiums;
- COBRA premium payments;
- Teeth whitening or bleaching;
- Personal trainer;
- Cosmetic surgery;
- Equipment that is not medically necessary.

Contribution Limits

Under the provision of the Flexible Health Care Reimbursement Account, you can elect a minimum of \$200 to a maximum of \$2,500 annually to be deducted in equal amounts from your paychecks on a pre-tax basis.

Forfeiture of Contributions

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

Eligibility

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

Enrollment

Eligible employees may enroll within 31 days from their date of hire or appointment, or within 31 days of when you first receive your benefits information, whichever is later. If you do not enroll when you first become eligible for the plan, you may enroll during the annual open enrollment period (usually held in November) for the Plan Year beginning January 1. A Plan Year is defined as the calendar year. In addition, you may be able to enroll in the Plan outside the open enrollment period if you experience a change in your life that has an impact on your benefits.

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

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

Change in Amount Deducted

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

Change in Status – (Qualifying Events)

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

Qualifying Events

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. The termination or commencement of employment of your spouse, the switching from part-time to full-time employment status (or vice versa) by you or your spouse;
5. You, your spouse, or eligible dependent begins or returns from an unpaid leave of absence; or
6. Such other events that the Administrator determines will permit the revocation of an election (and, if applicable, the filing of a new election) during a Plan Year under regulations and rulings of the Internal Revenue Service.

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

Effective Date of Change in Status

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

Plan Administrator Adjustments to Your Deposits

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

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

End of Employee Deposits

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

If you die during a plan year, your spouse (or, if none, your executor or administrator) may be reimbursed from your unused account balances for eligible expenses as permitted by the plan. Claims must be submitted within 120 days of your death.

Forfeited Deposits

Each Plan year you can use the Flex Health Care Reimbursement Account to pay for eligible expenses you incur during that plan year, and the grace period or until you become ineligible for the plan. Your account will remain open for four months beyond the end of that plan year.

Grace Period

Effective January 1, 2010, we adopted a “**grace period**” provision for the Flex Medical Reimbursement Account. Any unused account balance at the end of the calendar year may be carried forward for up to 2 ½ months into the following year (March 15). During that period you will be able to incur expenses and submit claims using available funds from the previous year’s account. Accounts will remain open through April 30 to allow time to submit claims for expenses incurred during the previous calendar year and the grace period.

Note: You must be an active participant on the last day of the plan year (December 31st) in order to be able to use the grace period feature.

This restriction has been imposed by the IRS in return for the tax advantages provided by the accounts. Forfeited funds will be used by the University to defray costs of the administration of the plan.

Effects on Your Salary

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

Claims Procedures and Reimbursement

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

You can either use your Flex debit card and submit receipts if requested or you can pay for covered expenses then submit the medical reimbursement form with the corresponding receipts to Crosby Benefits Systems (our third party administrator). In most instances, by using the debit card for eligible products and services you will not need to wait for reimbursement. After using your Flex Debit Card to make a purchase, transactions are reviewed by Crosby Benefits Systems. Some card transactions are automatically approved and need no further action by you. Other transactions will require you to submit receipts to prove your expenses are eligible according to IRS rules. If a card transaction does not meet the necessary requirements for automatic approval, you will be notified by email or mail by Crosby.

To submit a claim form to Crosby, you must complete a Medical Care Reimbursement Request form which can be obtained through the Human Resources website at <http://www.brandeis.edu/humanresources/benefits> or in the Office of Human Resources. The reimbursement request form must be completed and sent directly to Crosby. All requests for reimbursement must include a receipt showing the service or product provided, to whom, by whom, the amount charged and the date. Crosby must receive the completed claims between the 1st and 15th of the month to be reimbursed by the last day of the month. Completed claims received by Crosby between the 16th and 31st of the month will be reimbursed by the 15th of the following month. If the claim cut off or processing dates fall on a weekend, the deadline is extended to the following Monday. Reimbursement checks are issued on a bi-monthly basis. Direct Deposit is available by completing a Direct Deposit Authorization form.

Submit the reimbursement form(s) with supporting documentation directly to one of the following:

Reimbursement Portal: www.MyCrosbyBenefits.com

Email: servicecenter@crosbybenefits.com

Fax: 978-367-9626

Mail: Crosby Benefit Systems

PO Box 25172

Lehigh Valley, PA 18002-5172

Deadline to Submit Claims

You can submit claims for reimbursement up until April 30th following the plan year for eligible services received through March 15th following the plan year. The **IRS requires that any funds not used by the end of this period must be forfeited**. Because of this forfeiture requirement, it is essential that you estimate your expected health care expenses carefully.

Flex Debit Card

After using your Flex Debit Card to make a purchase, transactions are reviewed by Crosby Benefit Systems Crosby). Some card transactions are automatically approved and need no further action by you. Other transactions will require you to submit receipts (or invoices) to prove that your FSA expenses are eligible according to IRS rules. If a card transaction does not meet the necessary requirements for automatic approval, you will be notified by email or mail.

How does the Flex Debit Card work?

You simply present the debit card to a qualifying provider or merchant. If charges meet basic eligibility requirements and the necessary funds are available, the provider receives direct payment. You will be notified by email or mail if you need to submit receipts proving your expense is FSA eligible.

In general, when am I *not* required to submit receipts?

You do not need to submit receipts for:

- Recurring expenses
- Co-payments (if enrolled in employer's medical plan)
- Prescriptions
- Purchases from an IIAS retailer

In general, when am I *required* to submit receipts?

You are required to submit receipts for:

- Co-payments (if not enrolled in employer's medical plan)
- Vision and dental expenses
- Combined eligible and ineligible purchases
- Other non-confirmable purchases

What if I lose my receipt or purchase an ineligible item with the debit card?

If you are unable to substantiate a card purchase because you have lost your receipt or purchased an ineligible item, you can refund your account. To do this, submit your payment along with a completed Refund Form which can be found under "Forms" in the Participant Area at www.crosbybenefits.com.

What happens if I do not substantiate my expense?

If you do not substantiate expenses, here is what you can expect:

- Two requests for receipts will be sent to you by email or mail.
- If the request is not satisfied within 90 days of the transaction, your expense will be considered ineligible.

- Your card will be temporarily deactivated.
- You must mail a check to cover ineligible amounts to reactivate your card. Your card will be reactivated approximately four business days after your check is received.

How do I know what the available balance is on my Flex Debit Card?

Your available balance is your annual election minus previous eligible purchases made with the flex debit card or via traditional reimbursement. Please note, if your purchase exceeds your available balance, the transaction will not be approved at time of purchase.

Am I issued a new card every year I participate?

No. As long as you do not have a break in participation, you should continue to use your current Flex Debit Card until the expiration date printed on it. If you are an active participant at the time the card expires, a new one will be mailed to you.

What if my card gets stolen and someone tries to buy products or services with my card?

Contact Crosby immediately if your card is lost, stolen or if you do not recognize a transaction as one of your own. A Crosby representative will assist you with getting a new card and guide you through the transaction dispute process.

What if I don't want to use the debit card?

You do not need to use the Flex Debit Card. You can submit your eligible expenses directly to Crosby for reimbursement.

PLEASE NOTE: *Effective January 1, 2011, over-the-counter medicines and drugs can be reimbursed only if prescribed by a physician. This change does not apply to medical supplies such as insulin (even if purchased without a prescription), or other health care expenses such as medical devices, eyeglasses, contact lenses, bandages, co-pays and deductibles.*

GROUP TRAVEL ACCIDENT INSURANCE PLAN

Overview of Benefit

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

Eligibility

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

Definition of Injury

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

Definition of Loss

Loss as used in the Accidental Death & Dismemberment schedule with reference to hand or foot means the actual and complete severance through or above the wrist or ankle joint; as used with

reference to eye means irrecoverable loss of entire sight thereof; as used with reference to speech means complete and irrecoverable loss of speech; as used with reference to hearing means complete and irrecoverable loss hearing in both ears; and as used with respect to thumb and index finger means the actual and complete severance through or above the metacarpophalangeal joints.

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

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

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

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

Exclusions

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

- Intentionally self inflicted injury, suicide or attempted suicide, whether sane or insane;

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

Claims Procedure

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

Payment of Benefits

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

GROUP LONG TERM CARE INSURANCE

Benefit Overview

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

Eligibility

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

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

Important Note

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

SOCIAL SECURITY

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

Effective Date	Tax Rate	
2014	FICA	6.20% of the first \$117,000* of earnings
	MEDICARE	1.45% on all earnings

*Figure subject to change annually.

WORKERS' COMPENSATION

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

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

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

After this period, individuals may continue participation in the plan(s) at their own expense (100% of the premium). Participation in the plan(s) may continue for a maximum of 24 months. For purposes of this policy, 24 months is measured from the date workers compensation benefits commence. Participation in the plans(s) will terminate the earlier of the following events: the first of the month in which the employee reaches age 65, the date the employee becomes eligible for Medicare, or first of the month in which the employee fails to submit their health and/or dental insurance premium.

TUITION REMISSION for EMPLOYEES

Benefit Overview

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

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

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

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

Eligibility

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

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

To Apply

Employees wishing to enroll in a course must complete a Tuition Remission application, which can be found in the Office of Human Resources or online at <http://www.brandeis.edu/humanresources/benefits/tuition/employees.html>. Employees must have his or her supervisor/department head and the course instructor sign the Tuition Remission Application and (if applicable) Graduate Tax Exemption Form before its submission to the Benefits section. The Assistant Vice President for Human Resources grants approval for all tuition remission requests.

NOTE: Tuition remission applications for courses in the Rabb School of Continuing Studies or the Summer School Program will not need an instructor signature in order to submit the tuition remission application.

Course Registration and Billing

Employees **MUST** officially register for all classes. The application for tuition remission must be signed by a representative of the **University Registrar, Summer School or Continuing Studies** before it will be accepted by the Benefits section of the Office of Human Resources. The application for tuition remission are due no later than the last day of the add/drop period. Employees must follow the academic regulations as stated in the **Bulletin** and the deadlines indicated on the **Academic Calendar**.

The Registrar enrolls all employees as “Special Students”. Since regular students receive preference for available seats, applications for tuition remission do not guarantee enrollment for employees. Employees wishing to matriculate in a Brandeis degree program must contact the appropriate admissions office about enrollment requirements.

The Benefits section will notify Student Financial Services of the amount of tuition remission the employee will receive and Student Financial Systems will credit the employee’s account. Tuition remission benefits do not extend to any registration fees, late or special course fees. If an employee received a pro-rated tuition remission benefit, he or she will be responsible for the remainder of the charges on their student account.

Dropping/Withdrawing a Class

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

Taxation of Graduate Level Tuition Benefits

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

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

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

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

TUITION REMISSION for EMPLOYEE SPOUSES

Benefit Overview

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

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

Eligibility

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

Course Enrollment and Billing

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

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

TUITION REMISSION for DEPENDENT CHILDREN (revised 7/1/08)

Benefit Overview

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

*excludes full-time faculty in the Rabb School

Eligibility

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

1. One of the parents is:
 - a. A full-time professor, associate professor, assistant professor, research professor, associate research professor, assistant research professor, professor of the practice, associate professor of the practice, distinguished scientist, senior scientist or senior fellow at Brandeis University;
 - b. "A full-time instructor, senior lecturer, lecturer, and all faculty who hold 'in-residence' status, except those who have an affiliation only with a Center or Institute who has completed three years of full-time service";
 - c. Or deceased or retired by Brandeis University and the date of death or retirement was July 1969 or later and on the date of death or retirement, such parent was a full-time professor, associate professor, or assistant professor of the University and had been in its employment for a period of five years or more. **This provision is limited to tuition remission at Brandeis University only and does not apply to tuition remission at other colleges or universities.**
 - d. A full-time member of the senior management staff.
2. The student is a natural born, adopted, foster child or stepchild. A foster child must have resided in the employee's home for five years prior to enrollment and the employee must have supported the foster child. **Proof of dependency under IRS regulations is required.**
3. The student meets all requirements and is accepted by the Admissions Committee as a full-time matriculated student in the undergraduate program.

Children Attending Brandeis University

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

Applications for this benefit are available to eligible faculty members by contacting the Benefits section in the Office of Human Resources, MS 118. All applications must be completed and forwarded to the Director of Benefits a minimum of two months prior to the semester for which the tuition remission is desired. A photocopy of the top portion of the latest IRS form listing the student as a dependent must be

submitted before the tuition remission benefit will be granted. Faculty members must reapply for this benefit every academic year.

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

Children Attending Other Educational Institutions

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

Full-time faculty who hold the title of professor, associate professor, assistant professor, lecturer, instructor or artist-in-residence and were hired on or after January 1, 1985:

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

Full-time senior scientist or senior fellow:

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

Full-time faculty who hold the title of research professor, associate research professor, assistant research professor, professor of the practice, associate professor of the practice, senior lecturer and faculty who hold "in-residence" status (effective July 1, 2008):

A tuition remission benefit of \$3500 per year for 4 undergraduate years or 75% of another institution's tuition, whichever is less, is provided to meet tuition costs at an institution other than Brandeis University.

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

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

Application

To apply for these tuition remission benefits, please contact the Benefits section in the Office of Human Resources for an application. All applications must be completed and must include a copy of the top portion of the employee's latest IRS tax document listing the student as their dependent child. All applications must be forwarded to the Benefits section of the Office of Human Resources at MS 118 at least two months prior to the start of the semester for which tuition remission is desired. Upon receipt of the application, a letter will be sent to the school to verify the student's full-time attendance and the tuition charges. Once all required information is received, the Office of Human Resources will send payments directly to the institution.

Faculty members will receive a copy of the approved tuition remission application in campus mail. Faculty members must reapply each academic year for this benefit.

Junior Year Abroad Students

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

Please note TUITION REMISSION PLAN FOR DEPENDENT CHILDREN OF FACULTY

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

SUMMER SCHOOL AND HIGH SCHOOL PROGRAMS

Benefit Overview

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

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

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

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

Eligibility

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

To Apply

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

Registration and Billing

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

ACTIVITIES AND SERVICES

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

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

Cultural Activities

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

Use of Libraries

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

Daycare – Lemberg Children's Center, Inc.

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

The Human Resources 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 faculty members, 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.

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 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. Faculty are invited to participate. A schedule of services is listed in the Brandeis Reporter.

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

Employee Assistance Program

All employees are eligible for free confidential legal, family and financial counseling through LifeScope. www.LifeScopeEAP.com

SUMMARY PLAN DESCRIPTION

The following information, together with the accompanying Benefits and Services Handbook and your Evidence of Coverage Handbook or Certificate of Insurance Handbook issued to you by Tufts Health Plan is the Summary Plan Description required by the Employee Retirement Income Security Act of 1974. All inquiries relating to the following information should be referred directly to the Plan Administrator.

Plan Name: **Brandeis University Medical Insurance Plan**

Plan Number: **503**

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

Plan Administrator: **Brandeis University**
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 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 Medical Insurance Plan:

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

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

as set forth in the accompanying Benefits and Service Handbook

Plan Funding:

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

Amendment and Termination of Plans:

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

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

No Employment Rights:

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

Union Agreements:

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

Support Order Procedures:

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

Claims Procedures:

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

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

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the

plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under health care plans as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review these summary plan descriptions and the documents governing the health care plans on rules governing your COBRA coverage.
- Reduce or eliminate any exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 month after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person who has sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

SUMMARY PLAN DESCRIPTION

The following information, together with the accompanying Benefits and Services Handbook and your Subscriber Certificate issued to you by Brandeis University is the Summary Plan Description required by the Employee Retirement Income Security Act of 1974. All inquiries relating to the following information should be referred directly to the Plan Administrator.

Plan Name: **Brandeis University Dental Insurance Plan**

Plan Number: **511**

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

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

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

as set forth in the accompanying Benefits and Service Handbook

Plan Funding:

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

Amendment and Termination of Plans:

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

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

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

No Employment Rights:

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

Union Agreements:

The Plan is maintained, in part, pursuant to 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.

Denial of Claims:

If you 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 and your group insurance certificate issued to you by Standard Insurance Company is the Summary Plan Description required by the Employee Retirement Income Security Act of 1974. All inquiries relating to the following information should be referred directly to the plan administrator.

Plan Name: **Brandeis University Group Life Insurance Plan**

Plan Number: **505**

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

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

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

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 contract year basis beginning on each December 1 and ending on each November 30.

Administration of Group Life Insurance Plan:

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

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

as set forth in the accompanying Benefits and Service Handbook

Plan Funding:

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

Amendment and Termination of Plan:

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

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

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

No Employment Rights:

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

Union Agreements:

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

Claims Procedure for Life Insurance Claims:

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

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

Initial Determination:

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

Appealing the Initial Determination:

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

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

Notification of Final Claims Decision:

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

If Standard Insurance Company denies the claim on appeal, Standard Insurance Company will send you a final written decision that includes:

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

STATEMENT OF ERISA RIGHTS

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all Plan documents, including insurance contracts and copies of all documents filed by the Plan administrator with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of Plan documents and any other Plan information upon written request to the Plan Administrator. The Administrator may make reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person who has sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

SUMMARY PLAN DESCRIPTION

The following information, together with the accompanying Benefits and Services Handbook and your group insurance certificate issued to you by Standard Insurance Company is the Summary Plan Description required by the Employee Retirement Income Security Act of 1974. All inquiries relating to the following information should be referred directly to the Plan Administrator.

Plan Name: **Brandeis University Group Long Term Disability Insurance Plan**

Plan Number: **508**

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

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

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 contract year basis beginning on each December 1 and ending on each November 30.

Administration of Group Long Term Disability Insurance Plan:

The Plan is administered by the Plan Administrator with benefits provided in accordance with the provision of the applicable group policy issued by Standard Insurance Company. The Plan is fully-insured. Standard Insurance Company is solely responsible for financing and providing the benefits under the insurance

policies and contracts. The University has no liability for any benefits due, or alleged to be due, under any such insurance policies or contracts.

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

as set forth in the accompanying Benefits and Service Handbook

Plan Funding:

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

Plan Amendment of Termination:

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

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

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

No Employment Rights:

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

Union Agreements:

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

Claims Procedures for Disability Claims

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

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

Initial Determination:

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

If your claim is extended due to your failure to submit information necessary to decide your claim, you will be provided at least 45 days from the date of your receipt of the notice within which to provide the

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

Appealing the Initial Determination:

If your claim for a benefit is denied in whole or in part, you will receive a written explanation of the reason for the denial. On any wholly or partially denied claim, you or your representative may appeal to us for a full and fair review. You have 180 days to file an appeal of a denial of your claim. You may request, free of charge, copies of all documents, records, and other information relevant to your claim; and submit written comments, documents, records and other information relating to your claim, and in the case of a plan providing disability benefits, constitute a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant diagnosis without regard to whether such advice or statement was relied upon in making the benefit determination. The review will be conducted by an individual who is neither the person who made the initial review determination nor a subordinate of such person and no deference will be afforded to the initial review determination. If an adverse determination is based on medical judgment, the person conducting the appeal review must consult with a qualified health care professional during the review. If the adverse determination is upheld on appeal review, the Company will provide written notice to you that includes the reason for the adverse determination, the reference to the plan provision on which the decision is based, a statement that you will be provided, free of charge, copies of all information relevant to the claim, copies of any rules, guidelines or protocols used to make the adverse decision, an explanation of the scientific or clinical judgment that supports the decision if such decision is based on medical necessity or a similar exclusion or limitation. You will also be advised of your right to bring a civil action under Section 502(a) of ERISA following a continued denial of a claim after appeal review. You will receive a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information regarding the voluntary appeals procedure. You will also receive a statement indicating that, "You and your Plan may have other voluntary alternate dispute resolution options, such as mediation. For more information you may contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

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

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and collective

bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person who have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

SUMMARY PLAN DESCRIPTION

The following information, together with the accompanying Benefits and Services Handbook is the Summary Plan Description required by the Employee Retirement Income Security Act of 1974. All inquiries relating to the following information should be referred directly to the Plan Administrator.

Plan Name: **Brandeis University Retirement Plan for Faculty, Professional and Administrative Staff**

Plan Number: **001**

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.

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

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

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

Plan Year:

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

Administration of Retirement Plan:

Benefits under the plan are provided by annuity contracts and mutual funds custodial accounts issued to Participants by TIAA-CREF and Fidelity Investments. The University is the Administrator of the Plan and has designated the Associate Vice President for Human Resources to be responsible for Plan operation. The Plan Administrator is responsible for enrolling participants, forwarding Plan

contributions for each participant to the fund sponsors selected, and performing other duties required for operating the Plan. The Plan Administrator has the discretionary authority to interpret and administer the Plan. Subject to the request for review of denied claims described below, the Plan Administrator's decisions are final and binding.

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

as set forth in the accompanying Benefits and Service Handbook

Plan Funding:

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

Pension Plan Insurance:

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

Non-assignment of Benefits:

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

Investment Responsibility:

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

Amendment and Termination of Plan:

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

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

No Employment Rights:

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

Union Agreements:

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

Support Order Procedures:

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

Retirement Plan Claims Procedures:**Filing a Claim for Benefits:**

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

Processing the Claim:

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

Denial of Claim:

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

Review Procedure:

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

Decision on Review:

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

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person who have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

SUMMARY PLAN DESCRIPTION

The following information, together with the accompanying Benefits and Services Handbook is the Summary Plan Description required by the Employee Retirement Income Security Act of 1974. All inquiries relating to the following information should be referred directly to the Plan Administrator.

Plan Name: **Brandeis University Flexible Dependent Care Reimbursement Account**

Plan Number: **512**

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

Plan Administrator: **Brandeis University**
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.

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 Flexible Dependent Care Reimbursement Account Plan:

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

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

as set forth in the accompanying Benefits and Service Handbook.

Plan Funding:

The Plan is financed by contributions from the participating employees.

Amendment and Termination of Plans:

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

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

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

No Employment Rights:

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

Denial of Claims:

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

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

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

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

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

records and other information, as well as his or her rights under ERISA to bring a civil action with respect to the denial of the claim.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person who have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

SUMMARY PLAN DESCRIPTION

The following information, together with the accompanying Benefits and Services Handbook is the Summary Plan Description required by the Employee Retirement Income Security Act of 1974. All inquiries relating to the following information should be referred directly to the Plan Administrator.

Plan Name: **Brandeis University Flexible Health Care Reimbursement Account**

Plan Number: **519**

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

Plan Administrator: **Brandeis University**
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.

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 Flexible Dependent Care Spending Account Plan:

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

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

as set forth in the accompanying Benefits and Service Handbook.

Plan Funding:

The Plan is financed by contributions from the participating employees.

Amendment and Termination of Plans:

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

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

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

No Employment Rights:

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

Denial of Claims:

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

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

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

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

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

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person who have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

SUMMARY PLAN DESCRIPTION

The following information, together with the accompanying Benefits and Services Handbook is the Summary Plan Description required by the Employee Retirement Income Security Act of 1974. All inquiries relating to the following information should be referred directly to the Plan Administrator.

Plan Name: **Brandeis University Travel Accident Insurance Plan**

Plan Number: **510**

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

Plan Administrator: **Brandeis University**
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 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 Group Travel Accident Insurance Plan:

The Plan is administered by the Plan Administrator with benefits provided in accordance with the provision of the applicable group policies issued by The Hartford Life & Accident Insurance Company, Hartford Plaza, Hartford, Connecticut. The Travel Accident Insurance Plan is fully-insured. The Hartford Life & Accident Insurance Company is solely responsible for financing and providing the

benefits under the Travel Accident policy and contract. The University has no liability for any benefits due or alleged to be due, under any such insurance policies or contracts.

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

as set forth in the accompanying Benefits and Service Handbook

Plan Funding:

The Plan is financed by contributions from the Plan Sponsor.

Amendment and Termination of Plans:

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

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

No Employment Rights:

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

Travel and Accident Plan Claim Procedures:

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

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

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

Denial of Claims:

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

- Set forth the specific reasons for the denial,

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

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

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

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

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person who have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

SUMMARY PLAN DESCRIPTION

The following information, together with the accompanying Benefits and Services Handbook is the Summary Plan Description required by the Employee Retirement Income Security Act of 1974. All inquiries relating to the following information should be referred directly to the Plan Administrator.

Plan Name: **Brandeis University Educational Assistance Plan**

Plan Number: **518**

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

Plan Administrator: **Brandeis University**
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.

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 Educational Assistance Plan:

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

Plan Funding:

The Plan is financed by contributions from the Plan Sponsor.

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

as set forth in the accompanying Benefits and Service Handbook.

Amendment and Termination of Plans:

Brandeis University has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the University shall not have any obligation whatsoever to maintain a Plan for any given length of time. The University, by action of its Board, also may delegate any of its power and

duties with respect to the Plan or its amendments to one or more officers or other employees of the University. Any such delegation shall be stated in writing. The University will exercise good faith, apply standards of uniform application, and refrain from arbitrary action.

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

No Employment Rights:

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

Denial of Claims:

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

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

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

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

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

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the

plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person who have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.