MONMOUTH UNIVERSITY GROUP HEALTH INSURANCE PLAN

and Summary Plan Description

Effective January 1, 2020

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Introduction

Your Employer maintains the Plan for the exclusive benefit of its Eligible Employees and their Eligible Dependents**.** The Plan provides a variety of benefits, each of which is called a "component benefit." For a complete list of the component benefits offered under this Plan, see the Component Benefit Chart.

Each of these component benefits is governed by a contract issued by an insurance company, or another governing document prepared by the Employer and, for component benefits subject to ERISA, when read in conjunction with this document, constitute the official Plan document as required by ERISA §402. Each of the component benefits are summarized in a booklet issued by an insurance company, a summary description or another document prepared by the Employer and, for component benefits subject to ERISA, when read in conjunction with this document, constitute the Summary Plan Description required by ERISA §102. Copies of the insurance contracts, governing plan documents, insurance booklets, summary descriptions or other documents (referred to collectively as "Attachments" in this document regardless of whether they are physically attached) are hereby incorporated and can be obtained from the Employer.

Benefits are provided pursuant to an insurance contract or pursuant to a governing plan document adopted by Employer. If the terms of this document conflict with the terms of such insurance contract or governing plan document, then the terms of the insurance contract or governing plan document will control, rather than this document, unless otherwise provided herein or required by law.

General Information About the Plan

Name of Plan	Monmouth University Group Health Insurance Plan
Type of Plan	Health and Welfare Plan (providing the component benefit programs listed in the Component Benefit Chart)
Plan Year	January 1 – December 31
Employer and Plan Sponsor	Monmouth University 400 Cedar Avenue West Long Branch, NJ 07764 Tel: 732- 571-3470
Employer Identification Number	21-0634584
ERISA Plan Administrator	The Employer at the address and phone number above.
Agent for Service of Process	General Counsel Monmouth University 400 Cedar Avenue West Long Branch, NJ 07764 Legal service may also be served on the Plan Administrator at the address above.
Sources of Contributions and Funding Method	Employer and Employee Contributions. Employer contributions are paid from the general assets of the Employer and are not provided through a trust.
Plan Number	501
Type of Administration:	Administration is provided by insurance administrators and/or claims administrators Where a component benefit is insured, the type of administration is insurer administration and the insurance company serves as the Claims Administrator. Self-insured benefits, if any, are administered by a third-party Claims Administrator. As Claims Administrator, these companies are responsible for (1) determining eligibility for and the amount of any benefits payable under their respective component benefit program, and (2) prescribing claims procedures to be followed and the claims forms to by

	used by employees pursuant to their respective component benefit program.
COBRA Administrator	Plan Administrator at the contact address indicated above.
Named Fiduciary	The Named Fiduciary for the Plan is the Employer. The Claims Administrators have generally been designated to act on behalf of the Named Fiduciary for purposes of claims administration.
Privacy Official	Director of Human Resources
Individuals or Classes of Employees with Access to Protected Health Information	Privacy Official Office of Human Resources Office of Payroll Office of the Controller Office of Internal Audit Information Management Office of the General Counsel Such other classes of individuals identified by the Plan's Privacy Official as necessary for the Plan's administration
Governing Law	Except to the extent federal law applies, this Plan shall be construed, administered and enforced according to the laws of New Jersey.

Important Definitions

CAPITALIZED TERMS	MEANING
ACA	"ACA" means the Patient Protection and Affordable Care Act.
Children	"Children" means natural children, children of your Civil Union Partner, stepchildren, legally adopted children, children placed with you for adoption, and children under your legal guardianship.
Civil Union Partner	"Civil Union Partner" means an individual of the same sex with whom you are in a civil union and your civil union with that person has been registered with State of New Jersey.
COBRA	"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
Code	"Code" means the Internal Revenue Code of 1986, as amended.
Eligible Dependent	"Eligible Dependent" means any individual related to an Eligible Employee as described in the "Eligibility" Section of this document.
Eligible Employee	"Eligible Employee" means any Employee who meets the eligibility requirements described in the "Eligibility" Section of this document.
Employee	"Employee" means any common-law employee of Employer on the Employer's W-2 payroll.
Employer	"Employer" means the Plan Sponsor and any participating employers.
ERISA	"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.
FMLA	"FMLA" means the Family and Medical Leave Act of 1993, as amended.
HIPAA	"HIPAA" means the Health Insurance Accountability and Portability Act of 1996, as amended.
NMHPA	"NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.
Part-Time Employee	"Part-Time Employee" means an Employee who works less than 30 hours per week, is designated as a Part-Time Employee and has not been determined to be a Full-Time Employee under the look-back measurement method.
PHI	"PHI" means protected health information as defined under HIPAA.
QMCSO	"QMCSO" means a Qualified Medical Child Support Order, as defined in Section 609(a)(2)(A) of ERISA.
Seasonal Employee	"Seasonal Employee" means an Employee who is hired into a position for which the customary annual employment is six months or less.
Variable Hour Employee	"Variable Hour Employee" means an Employee whose hours are variable or uncertain so that the Employer cannot determine whether the Employee is reasonably expected to work on average at least 30 hours per week at the Employee's start date and the Employee has not been

	determined to be a Full-Time Employee under the look-back measurement method.
WHCRA	"WHCRA" means the Women's Health and Cancer Rights Act of 1998, as amended.

Component Benefit Chart

Below is a chart of component benefits offered under this Plan. In addition, the chart indicates whether:

- The component benefit is insured or self-insured
- The component benefit is a group health plan
- Eligible Employees will be automatically enrolled in the component benefit
- The component benefit is subject to ERISA
- Employee contributions are paid on a pre-tax or after-tax basis
- Whether Eligible Dependents may be enrolled in the component benefit
- The component benefit is grandfathered under the ACA

Copies of the insurance contracts, governing plan documents, insurance booklets, summary descriptions or other documents can be obtained from the Employer. This chart may be updated at any time without formal amendment to the Plan. Any update will be communicated to Participants as required by ERISA.

Component Benefit	Insured or Self Insured	Provider	Group Health Plan	Automatic Enrollment	ERISA Plan	Pre-Tax or After-Tax	Enroll Eligible Dependent
Medical	Insured	Horizon Blue Cross/Blue Shield of NJ	Yes	No	Yes	Pre-tax*	Yes
Prescription	Insured	Horizon Blue Cross/Blue Shield of NJ; Prime Therapeutics	Yes	No	Yes	Pre-tax*	Yes
Dental	Insured	Delta Dental NJ	Yes	No	Yes	Pre-tax*	Yes
Vision	Insured	Horizon Blue Cross/Blue Shield of NJ; Davis Vision	Yes	No	Yes	Pre-tax*	Yes
Basic Life & AD&D Insurance	Insured	Cigna	No	Yes (if provided in collective bargaining agreements)	Yes	N/A	N/A
Voluntary Supplemental Life Insurance	Insured	Cigna	No	No	Yes	After-tax	N/A
Short Term Disability	Insured	Cigna	No	Yes	Yes	N/A	N/A
Long Term Disability	Insured	Cigna	No	Yes	Yes	N/A	N/A
Travel Accident	Insured	AIG	No	No	Yes	Pre-tax	N/A
Employee Assistance Program (EAP)	N/A	RWJBarnabas Health	No	Yes	No	N/A	Yes
Health Reimbursement Arrangement (HRA)	Self-Insured	Discovery Benefits	Yes	No	Yes	Pre-Tax	N/A

Component Benefit	Insured or Self Insured	Provider	Group Health Plan	Automatic Enrollment	ERISA Plan	Pre-Tax or After-Tax	Enroll Eligible Dependent
Cafeteria Plan							
• Pre-Tax Premium Payment	N/A	Discovery Benefits	No	Yes	No	Pre-Tax	N/A
• Health Flexible Spending Account	Self Insured	Discovery Benefits	Yes	No	Yes	Pre-Tax	N/A
• Dependent Care Flexible Spending Account	Self-Insured	Discovery Benefits	No	No	No	Pre-Tax	N/A
Voluntary Long Term Care	Insured	Genworth Insurance Company	No	No	No	After-Tax	N/A
Voluntary Hospital Indemnity	Insured	Cigna	No	No	No	After-Tax	N/A
Commuter Benefits**	N/A	N/A – See Appendix D for Plan Document	No	No	No	Pre-Tax	N/A

*The cost of benefits for your Civil Union Partner are paid on an after-tax basis.

**Commuter benefits are fringe benefits not subject to ERISA and are included in the Plan for administrative convenience.

Eligibility

Eligible Employee

You may participate in the applicable component benefit programs that are part of the Plan if you are an Employee classified by the Employer, consistent with the Employer's personnel policies, as full-time faculty or non-faculty staff working at least 30 hours per week. In addition, if you are participating in the Plan and you were employed by the Employer before October 31, 2001 and are authorized to and regularly work at least 25 hours per week, you will continue to be eligible for the Plan.

You are not eligible for the Plan if you are classified by the Employer as adjunct faculty, an on-call employee, or a seasonal employee.

You may also participate in the Plan if you are a Full-Time Employee under the Affordable Care Act. "Full-Time Employee" means an Employee who is not a Seasonal Employee, who works at least 30 hours per week and is either designated as a Full-Time Employee or is determined to be a Full-Time Employee under the look-back measurement method. An Employee will be designated as a Full-Time Employee if he/she is reasonably expected to work at least 30 hours per week at his/her start date.

If you are a Variable Hour Employee, Part-Time Employee or Seasonal Employee, your status as a Full-Time Employee will be determined using a look-back measurement method. Please see Appendix A for further details.

Individuals who are not classified by the Employer, in its discretion, as employees under Section 3121(d) of the Code (including, but not limited to, individuals classified by the Employer as independent contractors and non-employee consultants) and individuals who are classified by the Employer, in its discretion, as employees of any entity other than the Employer do not meet the definition of Eligible Employee and are ineligible for benefits under the Plan, even if the classification by the Employer is determined to be erroneous, or is retroactively revised. In the event the classification of an individual who is excluded from the definition of Eligible Employee under the preceding sentence is determined to be erroneous or is retroactively revised, the individual shall nonetheless continue to be excluded from the definition of Eligible Employee and shall be ineligible for benefits for all periods prior to the date the Employer determines its classification of the individual is erroneous or should be revised.

Eligible Dependents

If you are an Eligible Employee, you may enroll your Eligible Dependents in certain component benefit programs under the Plan (see the

Component Benefit Chart).

Your dependents are eligible as follows:

Relationship	*Eligibility*
Legal Spouse or Civil Union Partner	Eligible
Non-Substantiated Civil Union Partner	Not Eligible
Your (or your Civil Union Partner's) Children who have not yet attained age 26	Eligible
Your (or your Civil Union Partner's) Children over age 26 who are mentally or physically disabled, as determined under applicable law	Eligible
Your Non-Civil Union Partner's Children	Not Eligible
Children for whom you are required to provide health coverage pursuant to a Qualified Medical Child Support Order (QMCSO).	Eligible

If you are married to another Eligible Employee, you may enroll as an Employee or as a dependent, but you cannot be covered as both. Children may be insured under one Employee's coverage only. You may be required to provide proof of your dependents' eligibility at any time. False or misrepresented eligibility information will cause both your coverage and your dependents' coverage to be irrevocably and immediately terminated and you will be responsible for the repayment of any benefits paid under false pretenses.

In general, when the terms of this document conflict with an insurance contract or governing plan document of a component benefit program, the contract or plan document will control. However, with respect to eligibility (including eligibility of employees and dependents as described above), this document will control. Thus, to determine whether you or your dependents are eligible to participate in the Plan, you should refer to the paragraphs above. The eligibility provisions of the component benefit programs are not applicable to the extent they conflict with this document.

Enrollment and Coverage Period

Automatic Enrollment

Once you are eligible, your Employer automatically enrolls you in those component benefits for which you are eligible at no cost to you, if any (see

the Component Benefit Chart to determine what component benefits to which this applies). Because enrollment is automatic, you do not need to take any action to enroll in these benefits.

Non-Automatic Enrollment

If you are requesting coverage for benefits other than any in which you are automatically enrolled**,** you must take action to elect these benefits through the enrollment process that will be described in a separate communication from your Employer.

If you are a new Eligible Employee, unless there are special circumstances as determined by Employer, you must enroll within a limited period of time following the date you first become eligible. In general, enrollment for subsequent plan years is made during the Plan's open enrollment period that is held near the end of the preceding plan year. You will be notified in a separate communication of the date of your enrollment and the enrollment deadline.

Restrictions on Mid-Year Changes

Component benefits which are paid on a pre-tax basis through the Employer’s cafeteria plan are subject to restrictions on changes to elections during the Plan Year. Election changes, such as enrollment in a component benefit or the amount of salary reductions for those benefits, may generally only be made upon initial enrollment or annually at open enrollment. However, there are limited circumstances in which you may make election changes mid-year that are consistent with, and on account of, such circumstances. Please see the Attachments for the Employer’s cafeteria plan for more information or contact your Employer.

Special Enrollment Rights Under HIPAA

If you are declining enrollment for yourself or your dependents (including your spouse or Civil Union Partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in a group health plan that is part of this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you or your dependents are eligible but not enrolled for the group health coverage, you may have a special enrollment right if you or your dependent’s Medicaid or Children’s Health Insurance Program (CHIP) coverage is terminated as a result of a loss of eligibility, or you or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP. You must request this special enrollment within 60 days of such loss of coverage or premium assistance subsidy determination.

Also, if you have a new dependent as a result of marriage, birth, adoption,

or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you have a special enrollment event due to a birth, adoption, or placement for adoption, coverage will generally be retroactive to the date of such event.

Federal law does not provide a special enrollment right where a new dependent is a Civil Union Partner or their dependents. However, where allowed by benefits providers, the Employer will offer special enrollment to new Civil Union Partners and their dependents, under the same terms and conditions as marital unions covered under federal guidelines. Please contact your Employer for additional information.

When Coverage Begins

Your coverage begins on the date indicated below following the completion of any required waiting period**.** If you enroll Eligible Dependents in a component benefit, generally their coverage begins when yours does.

Coverage Effective	Faculty: • 60th day of employment for medical, prescription, and vision • First day of the month following 60 days of employment for all other component benefits except as specified below • First day of the month following 90 days of employment for dental and flexible spending accounts • First day of the month following 30 days for life insurance • First of the month following one year of employment for long-term disability Non-faculty staff: • On 90th day of employment for medical, prescription, and vision • First day of the month following 90 days of employment for all other component benefits except as specified below • First day of the month following 30 days for life insurance • First of the month following one year of employment for long-term disability All employees: date of hire for EAP, short-term disability, travel accident, and commuter benefit

Termination of Participation

Your participation and the participation of your Eligible Dependents in the Plan will terminate effective as of the date indicated below.

Event	*Effective Date of Coverage Termination*
You are no longer employed by the Employer or are otherwise ineligible to participate.	The last day of the month in which you are no longer employed with the Employer or are otherwise ineligible to participate for medical, prescription, vision, and dental. The date of termination for all other component benefits.
Children turn age 26	The end of the month in which they turn age 26

Coverage may also terminate:

- if you fail to pay your share of an applicable premium,
- if your hours drop below any required hourly threshold,
- if you submit false claims,
- if the Plan is terminated, or
- for any other reason as set forth in the insurer booklets, benefit summaries or other governing documents for the component benefit program. You should consult the applicable Attachments for specific termination events and information.

Summary of Plan Benefits

Benefits

The Plan provides you and your Eligible Dependents with coverage under the component benefits described in the Component Benefit Chart. A description of each benefit provided under the Plan is set forth in the Attachments.

Contributions

The cost of the benefits provided through the component benefit programs will be funded in part by Employer contributions and in part by employee contributions. In most cases, employee contributions will be made on a pre-tax basis, though your Employer may also allow an after-tax election. Your Employer will determine and periodically communicate your share of the cost of the benefits provided through each component benefit program, and it may change that determination at any time.

Your Employer will make its contributions in an amount that (in your Employer's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. Your Employer will pay its contribution and your contributions to an insurer. Your contributions toward the cost of a particular benefit will be used in their entirety prior to using Employer contributions to pay for the cost of such benefit. With respect to component benefit plans that are group health plans, the Plan will provide benefits in accordance with the requirements of all applicable laws, such as COBRA, HIPAA, ACA, NMHPA and WHCRA.

Civil Union Coverage

If your Civil Union Partner (and/or Civil Union Partner's dependents) does not qualify as a dependent under Section 152, you may be subject to income tax on both the portion of the premium paid by Employer and the portion paid by you for your Civil Union Partner's (and their dependents') coverage.

Administrative Provisions

Named Fiduciary

The Named Fiduciary has the authority to control and manage Plan operation and administration. The Claims Administrators have generally been designated to act on behalf of the Named Fiduciary for purposes of claims administration.

The principal duty of the Named Fiduciary is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Named Fiduciary include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan.

The Named Fiduciary may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

The Named Fiduciary has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Named Fiduciary also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan. All determinations of the Named Fiduciary of any kind, including but not limited to interpretation of the Plan, application of the Plan, and factual determinations, shall be

presumed to be correct, reasonable and shall be conclusive and binding on all parties.

Amendment or Termination of the Plan

The Plan Sponsor has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the Board of Trustees of the Plan Sponsor, or its designee, including a committee authorized with such authority.

Administrative Costs

Your Employer will bear its incidental costs of administering the Plan.

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and Employer to the effect that you will be employed for any specific period of time.

No Guarantee of Tax Consequences.

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

Claims Procedures

Claims for Insured Benefits

For purposes of the determination of the amount of, and entitlement to, benefits of the component benefit programs provided under insurance contracts, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract. To obtain benefits from the insurer of a component benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form. In that case, the form is available from the Plan Administrator.

The insurer will decide your claim in accordance with its reasonable claims procedures, as required by ERISA if the component benefit is subject to

ERISA. The insurer has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurer denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurer for a review of the denied claim. The insurer will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA if the component benefit is subject to ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court). In addition, you must file suit within one (1) year of the date the final decision on your appeal is determined.

See the applicable insurance booklet for more information about how to file a claim and for details regarding the insurer's claims procedures, including any external review rights to which you may be entitled.

Claims for Self-Insured Benefits

For purposes of the determining the amount of, and entitlement to, benefits under the component benefit programs provided through the Employer's general assets, the Claims Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through such plans.

See the summary plan description or other governing document behind the Attachments for more information about how to file a claim and for details regarding the claims procedures applicable to your claim.

Deadlines for Filing Claims and Suit

The following are important deadlines that apply to your right to file a claim or a lawsuit in state or federal court:

- Unless otherwise specified in the applicable component benefit program documents, all claims for benefits must be filed no later than one (1) year following the date the claim arose.
- All suits must be filed no later than one (1) year following the date the final decision on the claim was made.

A failure to file a claim for benefits or, if applicable, a lawsuit, by the deadlines indicated above will result in the loss of your right to file such claim or lawsuit.

Questions

If you have any general questions regarding the Plan, or your eligibility for or the amount of any benefit payable under the plans, please contact the applicable Claims Administrator.

Statement of ERISA Rights

The Plan provides benefits that are subject to the requirements of ERISA and benefits that are not subject to ERISA. Including component benefit programs that are not subject to ERISA as part of this Plan is not intended to subject the component benefit program to ERISA

Your Rights and Privileges Under ERISA

As a participant in an ERISA plan you are entitled to certain rights and protections under ERISA. ERISA provides that, as a participant, you are entitled to:

- examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor (if any) such as annual reports and Plan descriptions;

- obtain copies of the component benefit program documents and other program information on written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies);

- receive a summary of the Plan's annual financial report, if any (the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report);

- 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 may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights; and

- Reduction or elimination of Exclusionary Periods of coverage for preexisting conditions under your group health plan (if any), 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 up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Fiduciary Obligations

In addition to creating rights for participants, ERISA imposes duties on the people who are responsible for the operation of the component benefit program:

- These people, called “fiduciaries” of the program, have a duty to operate the program prudently and in the interest of you and other program participants. Fiduciaries who violate ERISA may be removed and may be required to make good any losses they have caused the program.

- No one, including Employer or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining welfare benefits or exercising your rights under ERISA.

- If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan Administrator review and reconsider your claim.

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

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

- If it should happen that plan’s fiduciaries misuse the Program’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

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

Plan Document Execution Page

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the Monmouth University Group Health Insurance Plan, Monmouth University has caused this Plan to be executed in its name and on its behalf, on this ____ day of_____, 2020.

Monmouth University

By: _____

Title: _____

APPENDIX A: Determination of Full-Time Status and Coverage Period for Variable Hour, Part-Time and Seasonal Employees

A Variable Hour, Part-Time or Seasonal Employee's status as a Full-Time Employee will be determined on the basis of the number of hours of service the Employee has accrued during a standard or initial measurement period in accordance with the look-back measurement method. Different measurement periods apply for on-going Employees and for newly hired Employees.

Once a Variable Hour, Part-Time or Seasonal Employee has been determined to be a Full-Time Employee during a measurement period, and after a brief administrative period needed to review the information from the measurement period and to enroll the eligible Employee, the Employee is covered under the group health plan for a fixed stability period regardless of whether the Employee's actual hours of service during that stability period are on average at least 30 hours per week.

If your employment terminates and you are rehired after you have not performed an hour of service for at least 26 consecutive weeks, you will be treated as a new employee. If your employer chooses to apply the "rule of parity," a shorter break in service (equal to your period of service prior to the break, and no less than 4 weeks) will result in being treated as a new employee for these purposes.

This process is intended to comply with the requirements of the Affordable Care Act. For a more detailed explanation of how this process works and your eligibility, please contact your Employer.

For On-Going Variable Hour, Part-Time and Seasonal Employees	
Standard Measurement Period	November 1 to October 31
Standard Administrative Period	November 1 to December 31
Standard Stability Period	January 1 to December 31
For Newly Hired Variable Hour, Part-Time and Seasonal Employees	
Initial Measurement Period	12 months following date of hire
Initial Administrative Period	60 days
Initial Stability Period	12 months
Rule of Parity	Does not apply

APPENDIX B: Special Requirements for Group Health Plan Benefits

The component benefit programs which are group health plans (see the Component Benefit Chart to determine which component benefits are group health plans) have special requirements discussed below. The requirements discussed in this section do not apply to component benefits that are not group health plans.

Qualified Medical Child Support Orders

With respect to component benefit plans that are group health plans, the Plan will also provide benefits as required by any qualified medical child support order, or "QMCSO" (defined in ERISA § 609(a)), and will provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries, in accordance with ERISA § 609(c). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO, attached as Appendix C. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Benefits for Adopted Children

With respect to component benefit plans that are group health plans, the Plan will extend benefits to dependent children placed with you for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of other participants.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, 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 cesarean section. 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 the above periods. In any case, such plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires group health plans, such as this Plan, to cover reconstructive surgery and

related services following a mastectomy covered under this Plan, and affects group health plans that provide medical/surgical coverage for a mastectomy. Coverage under this Plan provides the coverage required by WHCRA including:

- Coverage for reconstructive surgery of the breast on which a mastectomy has been performed.
- Coverage for surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Coverage for prostheses and physical complications through all stages of a mastectomy, including swelling associated with the removal of lymph nodes.

This coverage will be provided in a manner that is determined in consultation with the attending physician and patient and will be subject to the same annual deductibles, coinsurance and/or co-payment provisions otherwise applicable under the Plan.

Family and Medical Leave Act of 1993

If you take a leave of absence that qualifies as a family or medical leave under the Family and Medical Leave Act of 1993 (an "FMLA leave"), coverage for you and your family members continues as long as you continue paying your portion of the cost of coverage during the FMLA leave. If a portion of your leave is a paid leave, the cost of coverage will continue to be deducted from your pay on a pre-tax basis. If a portion of your leave is unpaid (you are not receiving pay from Employer but may be receiving disability benefits from the insurance company), you will receive a letter outlining the portion of your leave that is unpaid and how to submit payment for insurance coverage. These payments must be made on an after-tax basis, since you will not have any pay from which payments can be deducted. For additional information on FMLA leaves, please contact your Employer.

Uniformed Services Employment and Reemployment Rights Act of 1994

If you take a leave of absence that qualifies as a leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), also referred to as a "military leave," you are entitled to continue coverage for up to 24 months as long as you give Employer advance notice (with certain exceptions) of the leave. If the entire length of the leave is 31 days or less, you will not be required to pay any more than the portion you paid before the leave. If your leave continues beyond 31 days, you are required to pay your portion of the premium, Employer's portion of the premium and a 2% administrative fee in order to retain coverage. If you take a military leave, but your coverage under the Plan is

terminated — for instance, because you do not elect the extended coverage — you will be treated as if you had not taken a military leave upon reemployment when determining whether an exclusion or waiting period applies upon your reinstatement into the Plan.

Under circumstances in which COBRA continuation coverage rights also apply (see the section entitled “Consolidated Omnibus Budget Reconciliation Act of 1985” below), an election to continue coverage during a military leave will be an election to take COBRA, and the two will run concurrently.

Health Insurance Portability and Accountability Act of 1996

Privacy and Security Rules

Compliance With HIPAA

This Section shall be interpreted in a manner that permits the Plan to comply with HIPAA and other federal and state laws regarding protection of PHI with respect to the Plan.

Use of Protected Health Information

The Plan will use and disclose protected health information (PHI), as defined in 45 CFR § 160.103, to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations as defined in the Plan HIPAA Privacy Notice (as defined in 45 CFR § 164.520) distributed to Participants and as otherwise permitted by the HIPAA privacy rules. The Plan will disclose PHI, other than enrollment and dis-enrollment information, summary health information, and information disclosed pursuant to an authorization, to your Employer only upon receipt of a certification from the Employer that the Plan document has been amended to incorporate the provisions under “Employer’s Obligations With Respect to PHI” below and that the Employer agrees to certain conditions regarding the use and disclosure of PHI and the adequate separation between the Plan and the Employer.

Employer’s Obligations With Respect to PHI

With respect to PHI, the Employer agrees to certain conditions. The Employer agrees to:

(a) not use or disclose PHI other than as permitted or required by the Plan document or as required by law;

(b) ensure that any agents (including a subcontractor) to whom the Employer provides PHI received from the Plan agree to the same

restrictions and conditions that apply to the Employer with respect to such PHI;

(c) not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

(d) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;

(e) report to the Plan any PHI use or disclosure inconsistent with the uses or disclosures provided for in this Article VI of which it becomes aware;

(f) make PHI available to an individual in accordance with HIPAA's access requirements;

(g) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(h) make available the information required to provide an accounting of disclosures;

(i) make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and

(j) if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

(k) ensure that the adequate separation between Plan and Employer, required in 45 CFR § 504(f)(2)(iii), is satisfied.

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

Access to PHI Within Employer

Adequate separation will be maintained between the Plan and the Employer. Only the individuals or classes of employees indicated in the "General Information Regarding the Plan" shall have access to PHI and may use and disclose PHI. If the persons described herein or any other employees do not comply with the Plan document, then the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. The Employer shall cooperate with the Plan to correct and mitigate any such noncompliance. The Employer will ensure that the provision of this Section are supported by reasonable and appropriate security measures to the extent that the persons described above have access to electronic PHI.

Privacy Official

The Privacy Official shall be responsible for compliance with the Plan's obligations under the Plan and HIPAA. Specific rules regarding the Privacy Official follow:

(a) Appointment, Resignation and Removal of Privacy Official. The Employer shall appoint one or more individuals to act as Privacy Official on matters regarding the Plan. The individual appointed as Privacy Official may resign by giving 30 days notice in writing to the Employer. The Employer shall have the power to remove that individual for any or no reason.

(b) Policies and Procedures. The Privacy Official and the Plan Administrator shall from time to time formulate such policies and procedures as they deem necessary for the Plan's compliance with this Article and HIPAA. No policy or procedure, however, shall amend any substantive provision of the Plan. The HIPAA policies and procedures are attached as Appendix D.

(c) Privacy Notice. The Privacy Official shall be responsible for arranging with the Employer, the Plan Administrator, and any third-party administrator for the issuance of, and any changes to, the Privacy Notice under the Plan.

(d) Complaint Contact Person. The Privacy Official shall be the contact person to receive any complaints of possible violations of the provisions of this Article and HIPAA. The Privacy Official shall document any complaints received, and their disposition, if any. The Privacy Official shall also be the contact to provide further information about matters contained in the Plan HIPAA Privacy Notice.

Consolidated Omnibus Budget Reconciliation Act of 1985

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most employers that sponsor group health plans to offer employees and their covered family members the opportunity to temporarily extend health coverage at group rates under certain circumstances when coverage under the plans would normally end. This coverage is called COBRA continuation coverage. Qualified beneficiaries are eligible for COBRA continuation coverage if coverage would be lost due to certain qualifying events.

Qualified beneficiaries include you and your eligible dependents who were covered under the Plan at the time of an initial qualifying event (see below) that would otherwise lead to termination of coverage.

Qualified beneficiaries also include a child born to or placed for adoption with the covered employee while enrolled under COBRA continuation coverage, who the employee enrolls under COBRA continuation coverage within the Plan's special enrollment period for newborns and adopted children. Qualifying events are described in the following paragraphs.

18-Month Qualifying Event

If your employment ends for any reason except gross misconduct, or if your hours are reduced below the minimum required to be eligible for health care coverage, you and your dependents who are qualified beneficiaries may continue health care coverage for up to 18 months from the date you and your dependents would otherwise lose coverage.

Coverage for your dependents who are qualified beneficiaries can be extended for up to 36 months from the original event date if you become divorced, legally separated, entitled to Medicare, or die within the 18- month period. COBRA coverage for your dependent children who are qualified beneficiaries can also be extended for up to 36 months if during the original 18-month period your dependent child no longer meets the definition of dependent under the Plan.

29-Month Qualifying Event (Due to Disability)

COBRA provides for an additional 11 months of health coverage. If you or another qualified beneficiary becomes disabled (as determined by the Social Security Administration) anytime within the first 60 days of COBRA continuation coverage. This additional 11-month extension is available for all qualified beneficiaries in the family, not just the disabled individual.

This 29-month period of coverage (the basic 18 months plus an

additional 11 months) begins when you or your dependent(s) would otherwise lose coverage because of your termination of employment or reduction of hours.

36-Month Qualifying Events

Your enrolled spouse and children who are qualified beneficiaries can continue coverage for up to 36 months from the date they would otherwise lose coverage due to one of the following qualifying events:

- Your death;
- Your divorce or legal separation from your spouse;
- Your child's loss of status as a dependent child under the terms of the Plan; or
- Your entitlement to Medicare.

Notification of Eligibility for COBRA

If your employment terminates or your hours are reduced, you will be sent an enrollment form for, and cost information on, continuing your benefits. The Covered Employee or Dependent, or their representative, must provide a completed enrollment form to the COBRA Administrator. The COBRA Administrator may require that additional information be provided, when necessary, to validate the Qualifying Event, before deeming the notice to be properly submitted. If the requested information is not provided within a reasonable period of time after the request, the COBRA Administrator reserves the right to reject the deficient notice, which means that the individual has forfeited their rights to COBRA Continuation Coverage.

If you or your dependents want the additional 11-month extension due to disability, you must notify the COBRA Administrator within 60 days after the date the disabled qualified beneficiary receives his or her Social Security disability determination and before the end of the initial 18-month COBRA continuation coverage period. You also must notify the COBRA Administrator within 30 days if Social Security determines you or your dependent is no longer disabled.

If you become divorced or legally separated, or your child no longer meets the eligibility requirements, you, your spouse, or your child is responsible for notifying the COBRA Administrator, within 60 days, in writing. COBRA rights will be forfeited if the COBRA Administrator is not notified within 60 days of the qualifying event.

The COBRA Administrator will in turn notify you or your dependents of your COBRA continuation rights within 14 days of receiving your notice. You must elect COBRA coverage within 60 days of receiving the notice, or, if later, within 60 days of the event causing the loss of coverage. COBRA rights will be forfeited if you or your dependent(s) do not elect COBRA coverage within this 60-day period.

Cost of COBRA Continuation Coverage

If you elect COBRA coverage, you pay the full cost of coverage for you and your dependents plus a 2% administration fee — in other words, 102% of the cost. The cost of COBRA continuation coverage for the additional 11 months due to disability (from the 19th to the 29th month) will may be up to 150% of the full cost of coverage.

The premium payments for the "initial premium months" must be paid for you (the employee) and for any spouse or dependent child by the 45th day after electing continuation coverage. The initial premium months are the months that end on or before the 45th day after the election of continuation coverage is made. Once a qualified beneficiary elects continuation coverage, the qualified beneficiary has the right to continue coverage subject to timely payment of the required COBRA premiums. Coverage will not be effective for any initial premium month until that month's premium is paid within the 45- day period after the election of continuation coverage is made.

All other premiums are due on the first of the month for which the premium is paid, subject to a 30-day grace period. A premium payment is considered to be made on the date it is sent. If you don't make the full premium payment by the due date or within the 30-day grace period, then COBRA coverage will be cancelled retroactively to the first of the month.

COBRA Period

The COBRA "clock" starts when your regular coverage would otherwise end. COBRA coverage will end before the end of the 18-, 29-, or 36-month period for any of the following reasons:

- You or your dependents become covered under another group health plan that does not contain any exclusions or limitations for pre-existing conditions that apply to you or your dependents.

- You or your dependents become entitled to Medicare (COBRA coverage ends only for the person who is entitled

to Medicare).

- You do not pay your premiums in a timely manner.
- Employer terminates all of its health plans.
- You or your dependents are on an 11-month disability extension and Social Security determines that you or your dependent is no longer disabled. In this instance, you are responsible for notifying the Claims Administrator within 30 days after the date Social Security determines you or your dependent is no longer disabled.

Additionally, if you lose group health coverage due to termination of employment or reduction of hours within 18 months of becoming entitled to Medicare, your dependent's COBRA continuation coverage will not end before 36 months from the date of your Medicare entitlement. Your initial COBRA continuation coverage generally must be identical to the coverage you had immediately before the qualifying event. However, qualified beneficiaries have the same enrollment and election change rights as active employees. For additional information on COBRA continuation coverage, rights, and obligations please contact your COBRA Administrator.

California Extension of Maximum Coverage Period for Medical Coverage

If you are a California employee and you and your covered dependents are covered under the insured medical benefit and become entitled to COBRA coverage with a maximum coverage period that is less than 36 months, you may be eligible for an extension of your coverage (medical only) up to a total of 36 months. You will be required to make a separate election for the California COBRA extension and will be notified of your right to this extension before the end of your 18- or 29-month coverage period.

COBRA and the Family and Medical Leave Act (FMLA)

An FMLA leave does not make you eligible for COBRA coverage. However, whether or not you lose coverage because of nonpayment of premium during an FMLA leave, you may be eligible for COBRA on the last day of the FMLA leave, which is the earliest to occur of:

- When you inform the Employer that you are not returning at the end of the leave;
- The end of the leave, assuming you do not return; and

- When the FMLA entitlement period ends.

For purposes of an FMLA leave, you will be eligible for COBRA, as described above, only if:

- You or your dependent is covered by the Plan on the day before the leave commences (or becomes covered during the FMLA leave); and

- You do not return to employment at the end of the FMLA leave; and

- You or your dependent loses coverage under the Plan before the end of what would be the maximum COBRA continuation period.

Medicare Entitlement & COBRA

Medicare entitlement is not a Qualifying Event for any individual who is covered under the Plan by virtue of current employment status and, in accordance with IRS Revenue Ruling 2004-22, it is not the Plan's intent to recognize a terminated Employee's Medicare entitlement as a second Qualifying Event for a spouse or child who is covered under the Plan as a COBRA Qualified Beneficiary. For these purposes, a "terminated Employee" is an Employee who lost Plan coverage due to termination of employment or reduction of hours.

COBRA Coverage for Civil Union Partners and Their Dependents

Federal law does not provide for COBRA continuation coverage for Civil Union Partners or their dependents. However, where allowed by benefits providers, the Employer will offer COBRA coverage in the event of a qualifying event, under the same terms and conditions as marital unions covered under federal guidelines. Please contact your Employer for additional information.

Plan Changes

During the time you or your dependents have COBRA coverage, there may be changes to the Plan, such as new deductibles, covered expenses, or changes to your premium. All changes to the Plan will also apply to your COBRA coverage.

Other Coverage Options

Instead of enrolling in COBRA coverage, there may be other coverage options for you and your family through the Health

Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Coordination of Benefits

If your Spouse or Civil Union Partner or children are enrolled in a medical or dental coverage under this Plan as well as another employer-sponsored plan, such as your Spouse or Civil Union Partner's plan at work, the medical or dental coverage under this Plan coordinates its coverage with the other plan. See the attached documents for the coordination of benefits provisions that apply to the applicable component benefit program.

APPENDIX C: Qualified Medical Child Support Order Procedures

Introduction

This Appendix C sets forth the procedures to be followed by Monmouth University group health plans upon receipt of qualified medical child support orders (QMCSOs), including National Medical Support Notices (NMSNs). These QMCSO procedures have been developed in accordance with Section 609(a) of the Employee Retirement Income Security Act of 1974 (ERISA), which requires group health plans to establish reasonable administrative procedures for determining whether orders are QMCSOs and administering the provision of benefits under QMCSOs. They are designed to assist the Plan Administrator in determining whether a particular order is a QMCSO and in carrying out its responsibilities relating to QMCSOs.

These procedures do not apply to benefits that are not "group health plan" benefits under ERISA, such as life insurance benefits and retirement benefits.

All actions related to QMCSOs and NMSNs must be taken in accordance with these procedures and must be performed on a timely basis.

A. What Is a QMCSO?

A QMCSO is a judgment, decree, or order, issued by a court or through a state administrative process, that requires health plan coverage for the child of a participant (called an "alternate recipient") and that meets certain legal requirements. Such orders typically are issued as part of a divorce or as part of a state child support order proceeding, and are typically drafted by divorce lawyers. Unlike NMSNs, they are not required to follow a standard format. As a result, they may vary widely in terminology, format, and sophistication. Federal law requires a group health plan to provide benefits in accordance with such an order, if it is "qualified."

A QMCSO may apply to an employer's major medical plan, as well as to other types of group health plans such as dental plans, vision plans, and health FSAs.

In general, a child who is an alternate recipient under a QMCSO must be treated the same as any other child covered by the plan. If the Medical Child Support Order is not qualified, the group health plan will not provide group health plan coverage to the child, unless the child is otherwise eligible for and enrolled in the plan. More information on QMSCOs can be found at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/qualified-medical-child-support-orders.pdf.

B. What Is an NMSN?

State child support enforcement agencies are required to use an NMSN when enforcing the provision of health care coverage to children under an employment-related group health plan. This is a standard form that was jointly developed by the DOL and HHS. When properly completed by the issuing agency, the NMSN will constitute a QMCSO.

In some cases, orders will refer to or require a plan to comply with state laws enacted in response to Section 1908A of the Social Security Act, which requires states to enact certain medical child-support laws in order to receive federal Medicaid funds. These state laws are designed to help state governments and non-employee parents obtain private-sector health coverage for children, including coverage under employer-sponsored group health plans.

The NMSN will normally be sent to the employer. If the employer determines that the NMSN cannot be implemented, the employer is required to notify the issuing agency, which is then responsible for notifying the child and/or parents. If the employer determines that the specified conditions that might prevent the NMSN from being are not present, the employer is then required to forward Part B of the NMSN to the Plan Administrator, at which point the Plan Administrator becomes responsible for complying with the applicable notification requirements.

C. What Are the Plan's Rights and Responsibilities Relating to QMCSOs and NMSNs?

Plans are not required to provide coverage in accordance with a child support order or other court order unless the order is “qualified” in accordance with ERISA §609(a). The Plan Administrator has the authority to determine whether an order meets the requirements of ERISA §609(a). If the order does not meet these requirements, the Plan need not (and should not) provide any benefits to the alternate recipient, unless the child is otherwise eligible for and enrolled in the Plan or the order's deficiencies are corrected by the parties.

Procedures for Determining Whether Orders Are QMCSOs

The procedures to be followed upon the receipt by the Plan Administrator of a child support order depend on whether the order is an NMSN or another type of order.

A. Upon Receipt of Any Order Other Than an NMSN

1. Notification to the Participant and the Alternate Recipient Upon Receipt of the Order

Upon receipt of any order other than an NMSN, the Plan Administrator must promptly provide written notification to both the participant and the alternate recipient(s) named in the order. The notification must inform the participant and the alternate recipient(s) that the Plan has received the order and should include a copy of the Plan's QMCSO Procedures.

For the participant, the Plan Administrator should send the notification to the participant at the address shown in the employer's records. If the participant is represented by legal counsel, the notification may be sent to the participant in care of the participant's legal counsel.

For the alternate recipient(s), the Plan Administrator should send the notification to the address in the order, or if the order does not specify such an address, to the last-known address shown in the employer's records. If there are multiple alternate recipients named in the order, a single notification may be sent addressed to those alternate recipients who are, so far as the Plan Administrator is aware, residing at the same address. If the alternate recipients are minors, the notification may be sent to them in care of the parent with whom they are residing or, if they are represented by legal counsel, in care of their legal counsel.

2. Review of the Order

The Plan Administrator must review the order using the checklist attached to these procedures to determine if it meets the legal requirements for a QMCSO. If the Plan Administrator considers it to be necessary or advisable, the Plan Administrator may seek the assistance of legal counsel in reviewing a proposed QMCSO.

3. Notification to the Participant and the Alternate Recipient Following Review of the Order

Within a reasonable time after receipt of the order, the Plan Administrator must notify the participant and alternate recipient of the determination that it has reached as to whether the order is, or is not, a QMCSO. If the Plan Administrator determines that the order is not a QMCSO, an explanation of the defective or missing provisions should be included.

4. Time Period for the Plan Administrator's Review

The Plan Administrator should review a proposed QMCSO as quickly as possible. Under normal circumstances, the Plan Administrator's review must be completed within 40 business days following receipt of the proposed QMCSO.

5. Combining Notifications to the Participant and Alternate Recipient

When the Plan Administrator is able to review a proposed QMCSO immediately upon its receipt of the proposed order, the Plan Administrator may provide a single notification to the participant and the alternate recipient(s) informing them of its receipt of the proposed order, of the Plan's QMCSO procedures, and of the determination it has made as to whether the proposed order should be recognized as a valid QMCSO. Alternatively, the Plan Administrator may include separate notifications in the same envelope sent to the participant or to the alternate recipient(s).

B. Upon Receipt of an NMSN

Upon receipt of an NMSN, the Plan Administrator must follow the “Instructions to Plan Administrator” that are included in Part B of the NMSN. In addition, because a properly completed NMSN is deemed to be a QMCSO under ERISA, the Plan Administrator must also ensure that the notifications to the participant and to the alternate recipient(s) that are required upon the receipt of a proposed QMCSO are also provided upon the receipt of an NMSN.

The required notifications can generally be provided by sending copies of the completed “Plan Administrator Response” to the NMSN to the parties using the addresses on Part B of the NMSN. In addition, if the NMSN is determined to be a QMCSO, the parties must be provided with certain information, such as the effective date of the child's coverage (or the steps necessary to effectuate coverage), a description of the coverage, and any forms or documents necessary to enroll in the Plan. (See the instructions to the NMSN.)

C. Designation of Representative

An alternate recipient may designate a representative to receive copies of notices that are sent to him or her with respect to an order. If an alternate recipient is a minor, the custodial parent or, in the case of an NMSN, the issuing agency, will be deemed to be the representative of the alternate recipient unless contrary instructions have been provided. If any party is represented by legal counsel, that party’s legal counsel will be deemed to be that party’s representative for purposes of the notification requirements in these procedures.

D. Disputes

Within 30 days after the date of the Plan Administrator's notice as to whether an order is a QMCSO, the parties (or their legal counsel) will have the right to submit written comments regarding the determination. After considering any comments received, the Plan Administrator will make a final determination as to the qualified status of the order. If no comments are received during the 30-day period, the decision will become final.

E. Resubmitted Orders

If an order (including an NMSN) is determined to not be a QMCSO, the parties or agency may submit a revised order to cure the deficiencies. If a revised order is submitted, the evaluation process in subsection A or B is repeated.

Additional Considerations

A. Forms and Information

Additional forms and information may be necessary to effectively administer benefits under an order that has been determined to be a QMCSO and to enroll the alternate recipient in the applicable plans. These forms and information include the following:

- The name and address of the alternate recipient's custodial parent, legal guardian, or other person(s) to whom the SPDs and other plan-related information and correspondence should be furnished following the alternate recipient's enrollment. Where an agency is involved (as in the case of a National Medical Support Notice), it may be necessary or appropriate to provide certain plan information and/or correspondence to the agency as well.
- A completed enrollment form, if required under the Plan.
- A change in the participant's cafeteria plan election, if applicable. If benefits required to be provided under a QMCSO are paid for on a pre-tax basis, the QMCSO may qualify as a permitted election change event under the Employer's cafeteria plan. If applicable, and if the cafeteria plan document permits an election change on account of the QMCSO, the participant may submit a change in his or her cafeteria plan election in accordance with the cafeteria plan's rules.
- The name and address of an individual to whom it is expected that benefit reimbursements may be made for the alternate recipient's child's claimed expenses. The QMCSO rules provide that if medical expenses are paid by either the alternate recipient or the alternate recipient's custodial parent or legal guardian, a plan must reimburse that person (not the employee) for those expenses. If expenses are submitted for reimbursement, information identifying the individual to receive payment should be provided to the Plan.

Note that a QMCSO may provide that a person or entity other than the participant is responsible to pay for the alternate recipient's coverage. In such cases, the Plan Administrator should indicate how and when payment is to be made. For example, payments might be required concurrent with each payroll period or on a monthly basis as required of qualified beneficiaries receiving COBRA continuation coverage. The Plan Administrator should also make sure that it has contact information for the person or entity who will be making the payments.

B. Alternate Recipient as “Beneficiary”

In general, the alternate recipient must be treated like any other covered child under each plan in which he or she is enrolled.

Unless a QMCSO is more restrictive, the alternate recipient should be given the same coverage as would be provided to any other dependent child under the Plan.

The alternate recipient should be treated as a qualified beneficiary and offered COBRA continuation coverage upon the occurrence of a COBRA qualifying

event (such as the participant's termination of employment or the alternate recipient's ceasing to qualify as a dependent child under the Plan due to age).

C. Effective Date of Enrollment

If an order is determined to be a QMCSO or an NMSN is determined to be valid, that order will be given effect as soon as administratively practicable following such determination or, if later, as of the date specified in the order. Retroactive coverage will not, however, be provided. If an employee is eligible for the Plan but is not enrolled, he or she will also be enrolled if his or her enrollment is necessary for the alternate recipient to have the coverage required under the QMCSO. However, if the employee has not yet satisfied the Plan's waiting period, enrollment of the alternate recipient and employee will be delayed until the employee has completed the waiting period.

D. Termination of Coverage

Coverage for the alternate recipient will cease, subject to COBRA, if the alternate recipient ceases to be eligible to participate in the Plan for any reason, including the following:

- The period for coverage under the QMCSO ends;
- The QMCSO is revoked or materially amended by a court of competent jurisdiction or through an administrative process;
- The participant ceases to be a participant under the terms of the Plan or an applicable component plan of the Plan;
- The participant ceases to be eligible for coverage under the terms of the Plan or an applicable component plan of the Plan; or
- Similarly situated beneficiaries cease to be eligible for coverage under the terms of the Plan or an applicable component plan of the Plan.

E. Special Consideration—Child Already Enrolled

The parties may submit an order (including a National Medical Support Notice) that purports to require that a child be covered under a plan in which he or she is already enrolled. In this circumstance, the Plan Administrator should process the order under these procedures but should also inform the parties of the child's status as a current beneficiary under the Plan.

F. Plans with Multiple Options

An otherwise-qualified order may identify a plan or type of coverage with multiple options without designating the option in which the alternate recipient is to be enrolled or the manner in which an option is to be chosen. In the case of an NMSN, the Plan Administrator should follow the instructions in the NMSN regarding plans with multiple options. For other orders, the Administrator should enroll the alternate recipient in the same option as the employee if the employee is enrolled in the Plan. Otherwise, the Plan Administrator may follow procedures similar to those in the NMSN. That is, the Plan Administrator may,

instead of rejecting the order, provide the parties with information about the available options and direct them to make a selection. If the Plan has a default option, the Plan Administrator may also notify the parties that the alternate recipient and employee will be enrolled in this option if a response is not received within a specified time period (e.g., 20 business days).

APPENDIX D: Commuter Benefits Plan

This Appendix D describes Monmouth University's ("Employer") Commuter Benefits Plan, and is intended to be a qualified transportation expense reimbursement plan under Code section 132(f). This Appendix D will apply to employees of the Employer effective January 1, 2020.

The following additional definitions apply for purposes of the Commuter Benefits Plan.

CAPITALIZED TERMS	MEANING
Employee	"Employee" means any common-law employee of Employer on the Employer's W-2 payroll at the time a Qualified Transportation Expense benefit is provided.
Participant	An employee who participates in the Commuter Benefits Plan pursuant to Sections 3 and 4.
Plan Administrator	Monmouth University
Qualified Parking	Parking provided to a Participant by the Employer: (i) on or near the Employer's business premises; or (ii) at a location from which the Employee commutes to work (including commuting by carpool, commuter highway vehicle, mass transit facilities, or transportation provided by any person in the business of transporting persons for compensation or hire). Parking on or near the Employer's business premises includes parking on or near a work location at which the Employee provides services for the Employer. Qualified Parking does not include: (1) the value of parking provided to an Employee that is excludable from gross income under Code section 132(a)(3) (as a working condition fringe), (2) reimbursement paid to an Employee for parking costs that is excludable from gross income as an amount treated as paid under an accountable plan in accordance with Treas. Reg. 1.62-2, or (3) parking on or near property used by the Employee for residential purposes. Parking is provided by the Employer if (i) the parking is on property that the Employer owns or leases, (ii) the Employer pays for the parking, or (iii) the Employer reimburses the Employee for parking expenses.
Qualified Transportation Expenses	Expenses incurred for Transportation in a Commuter Vehicle, Transit Passes, and/or Qualified Parking.
Transit Pass	Any pass, token, farecard, voucher, or similar item (including an item exchangeable for fare media) that entitles a person to transportation: (i) on mass transit facilities (whether or not publicly owned); or (ii) provided by any person in the business of transporting persons for compensation or hire in a highway vehicle with a seating capacity of at least six adults (excluding the driver).
Transportation Expense Account	The account established for each Participant electing to have Qualified Transportation Expenses reimbursed by the Commuter Benefits Plan.

Transportation in a Commuter Highway Vehicle	Transportation provided by the Employer to a Participant in connection with travel between the Participant's residence and place of employment. A commuter highway vehicle is a highway vehicle with a seating capacity of at least six adults (excluding the driver) and with respect to which at least 80 percent of the vehicle's mileage for a year is reasonably expected to be: (i) for transporting employees in connection with travel between their residences and their place of employment; and (ii) on trips during which the number of employees transported for commuting is at least one-half of the adult seating capacity of the vehicle (excluding the driver). Notwithstanding the foregoing, Transportation in a Commuter Highway Vehicle shall include transportation provided by a van pool within the meaning of Treas. Reg. 1.132-9(b) Q&A-21 and any superseding guidance.

1. Eligibility and Participation

All Employees of the Employer are eligible for the Commuter Benefits Plan. To become a Participant, an Employee must complete the forms provided by the Plan Administrator. Participation will end upon termination of employment.

2. Elections and Transportation Expense Accounts

Each Participant may elect in writing (including via electronic election) to reduce his or her compensation on a pre-tax basis and instead receive a fixed amount of Qualified Transportation Expenses for a future period. The election must include the date of the election, the amount of the compensation to be reduced (either a fixed dollar amount or fixed percentage), and the period for which the benefit will be provided. Elections may be changed each month and will be implemented as soon as administratively feasible.

The monthly election amount may not exceed the combined applicable monthly maximum statutory reimbursement amounts under Code Section 132(f)(2) for Transportation in a Commuter Highway Vehicle and Transit Passes, and Qualified Parking. For 2020, the maximum monthly reimbursement for Transportation in a Commuter Highway Vehicle and Transit Passes is $270, and the maximum monthly reimbursement for Qualified Parking is $270. These amounts may be adjusted in future years.

Each Participant’s Transportation Expense Account will be credited with the elected amount.

A Participant may carry forward any unused balance to future periods. Amounts elected are not refundable as cash and may only be used for Qualified Transportation Expenses, unless a Participant revokes an election before the compensation to which the election applies is available to the Participant. Any amounts remaining in a Participant’s Transportation Expense Account upon termination of employment will be forfeited after all payments and reimbursements for Qualified Transportation Expenses incurred prior to termination have been made.

3. Reimbursements

Claims for reimbursement must be submitted within 180 days after incurring the Qualified Transportation Expense (or within 90 days after termination of employment) on the form provided by the Plan Administrator. Reimbursements will not be made before an expense has been incurred or paid.

Reimbursements must be substantiated by receipts or other documentation as required by the Plan Administrator.

Cash reimbursement may be made for Transit Passes only if no voucher or similar item that may be exchanged for a Transit Pass is readily available for direct distribution by the Employer to Participants. If a voucher is readily available, the requirement that a voucher be distributed in-kind by the Employer is satisfied if the voucher is distributed by the Employer or by another person on behalf of the Employer. A voucher is not readily available if:

(1) the lowest cost monthly voucher available from a transit system has fees paid by the Employer that exceed 1% of the average annual value of the vouchers for the transit system;

(2) multiple transit systems meet the needs of individual employees in the area and the Plan Administrator determines the average voucher from each transit system has fees paid by the Employer that exceed 1% of the average annual value of the vouchers for the transit systems; or

(3) other restrictions effectively prevent the Employer from obtaining vouchers appropriate for distribution to employees (advance or minimum purchase requirements apply that prevent the employer from distributing monthly passes at regular intervals or in reasonable quantities, for example)

If a Participant dies, the Participant's designated beneficiary may submit claims for reimbursement. If no beneficiary is designated, the Plan Administrator will pay any amounts due in the following order: to the Participant's spouse or civil union partner, or if none, to the Participant's dependents, or if none, to the Participant's estate.

If the Plan Administrator determines that a Participant has received excess payments/reimbursements or has received taxable payments/reimbursements, the Plan Administrator shall notify such Participant and he or she shall repay the excess amount as soon as possible, but in no event later than 30 days after the date of notification. Each such Participant shall indemnify and reimburse the Employer for any liability the Employer may incur for making such payments, including but not limited to liability for failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If the Participant fails to timely repay an excess amount and/or make sufficient indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset the

Participant's salary or wages, and/or (ii) offset other benefits payable under the Commuter Benefits Plan.

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited one year after the date any such payment first became due.