The University reserves the right to amend this Plan at any time without the consent of any eligible employee, participant, or dependent. Although the University expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan coverage at any time without liability.
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INTRODUCTION

We hope that you and your family enjoy good health throughout your retirement years. Should medical treatment be required, however, Tufts University offers you and your eligible family members a choice of comprehensive health insurance options.

Every effort has been made to describe the Tufts University Retiree Health Insurance Plan (the “Plan”) accurately, completely, and in easy-to-read language. This booklet explains Tufts University’s requirements for participation in the Plan, your health coverage options, and related matters. Please refer to the related description of benefits, certificate of coverage, subscriber agreement, or evidence of coverage agreement for each health coverage option (an “Insurance Booklet”) for complete details on specific benefit coverage, definitions, exclusions, and limitations for that option.

To achieve the highest degree of coverage in the event of any injury or illness, as well as allowing you to manage your health care expenses, you must follow the predefined terms and conditions of the Plan and the particular coverage option you choose. Remember that if these provisions are not followed as described, Plan benefits may be reduced or denied.

Together, this booklet and the Insurance Booklets are the “Summary Plan Description” and the Plan document for the Retiree Health Insurance Plan.

While Tufts University’s current intention is to continue the Plan indefinitely, it reserves the right, at its discretion, to amend or terminate the Plan in whole or in part at any time with respect to any provisions, including, but not limited to, benefits, contributions, or coverage.

ELIGIBILITY

FOR YOURSELF

If you were receiving retiree health coverage from Tufts University on December 31, 1993, you are automatically eligible to participate in the Plan.

Alternatively, if you retired after December 31, 1993 and were covered by the Tufts University Health Benefits Plan as an active employee for at least the 12 months immediately preceding your retirement, you are eligible to participate in the Plan if, at retirement, you are at least age 60 and have 5 or more years of service with Tufts University; or your age plus years of service with Tufts University equals at least 75. Only benefit eligible employment, as determined under the Tufts University Health Benefits Plan, will be counted towards years of service.

If there are any additional requirements for eligibility under an Insurance Booklet, you must also satisfy those requirements to be eligible for the coverage described in that Booklet.
FOR YOUR ELIGIBLE DEPENDENTS

For your spouse to be eligible for coverage under the Plan, he/she must have been covered by the Tufts University Health Benefits Plan for at least the 12 months immediately preceding your retirement and continue to be your spouse throughout the coverage period.

For your same-sex domestic partner to be eligible for coverage under the Plan, he/she must have been covered by the Tufts University Health Benefits Plan for at least the 12 months immediately preceding your retirement and a signed Statement of Domestic Partnership must be on file in the Human Resources Benefits Office. Additionally, he/she must continue to be your domestic partner throughout the coverage period.

For your children to be eligible for coverage under the Plan they must be your legal children. The term “children” includes:

- Your biological children
- Your legally adopted children
- Your stepchildren who live with you full time in a regular parent-child relationship, and
- Any other child permanently living with you for whom you are the legal guardian.

In general, children may be covered to their 26\textsuperscript{th} birthday. However:

- Under the health plan, children may be covered until age 26 unless the child has access to his or her own and/or spouse’s employer-sponsored health insurance;
- Children who were covered under the Plan before age 19 up to age 26 and became incapable of self-sustaining employment due to a disability may be eligible for coverage beyond such age; and
- Children who were disabled adults when you began employment with the University and were enrolled when you were first eligible to do so are eligible for coverage beyond such age.

For purposes of this booklet, hereafter the term “dependent” will refer to spouse, same-sex domestic partner, and eligible children. Please note, in the case of a deceased employee who was eligible for retiree health benefits at the time of death, the surviving dependent(s) will be eligible for coverage.
ENROLLMENT

You and your dependents, if eligible, must enroll for retiree health coverage under the Plan when you first retire by completing and returning the forms to the University’s Human Resources Benefits Office within 30 days.

If you and your eligible dependents do not enroll in coverage under the Plan at the time of your retirement or if you or your eligible dependents voluntarily terminate your participation in the Plan, you and your dependents will irrevocably forfeit any right to participate in health coverage under the Plan thereafter.

NOTE: If you acquire a new dependent after you have enrolled in the Plan, for example, because you become married, then you may be able to add the new dependent to your Plan coverage under the special enrollment rules under HIPAA. Generally, special enrollment is available if you timely enrolled in the Plan and since enrolling you have acquired a new dependent (through marriage or the birth or adoption of a child) and wish to cover that person. As long as you meet the necessary requirements, you can enroll your new dependent(s) in the Plan within 31 days after the date of your marriage or the birth, adoption, or placement for adoption of your child.

RETIREE HEALTH INSURANCE PLAN BENEFITS

The post-retirement health benefits available to eligible retirees and their eligible dependents are divided into two categories based on the retiring employee’s and the eligible dependents’ ages:

<table>
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<tr>
<th>COVERAGE UNDER AGE 65</th>
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Retired employees who are under age 65 may elect, for themselves and their eligible dependents under age 65, health coverage that is the same health coverage they are enrolled in prior to retirement, although he/she may be eligible to change plans if he/she moves out of a plan’s service area or during Open Enrollment. Once the retiree or an eligible dependent reaches age 65, he/she is required to enroll in an age 65 or older plan. You will be contacted prior to your (or your dependent’s) 65th birthday regarding your options.

Below is a brief summary of the benefits available under the HMOs, Point-of-Service, and Preferred Provider Organization plans.

- **Health Maintenance Organizations/Exclusive Provider Organizations (HMO/EPO)**
  
  Benefits available under an HMO/EPO provide coverage for authorized medical treatment with low co-payments for office visits and for prescription drugs. The HMO/EPO requires that your care be directed by a primary care physician within the plan’s network of providers.
• **Point-of-Service Plan**

There are two levels of benefits available through the point-of-service plan. At the time you need care, the Plan allows you the freedom to choose whether you will receive care within the provider network (network care) or outside of the network (out-of-network care). If you choose to obtain out-of-network care, you have the freedom to see any provider but if you see an out-of-network provider, you will pay more for this care.

— **Network benefits** provide HMO/EPO-like coverage for eligible services with small co-payments for doctors’ visits and prescription drugs. Benefits are provided through the Plan’s established network of providers. To receive the highest level of coverage, care you receive must be directed by your primary care physician.

— **Out-of-network benefits** allow plan participants the choice of receiving health coverage from any health care provider. Most services received from out-of-network providers are covered at 80% of the Plan’s usual and customary amount after satisfying the Plan’s required deductibles.

• **Preferred Provider Organization (PPO)**

A health care organization composed of physicians, hospitals, or other providers that provides health care services at a reduced fee. A PPO is similar to an HMO, but care is paid for as it is received instead of in advance in the form of a scheduled fee. PPOs may also offer more flexibility by allowing for visits to out-of-network professionals at a greater expense to the policy holder. Visits within the network require only the payment of a small fee. There is often a deductible for out-of-network expenses and a higher co-payment. A policy holder will have a primary physician within the network who will handle referrals to specialists that will be covered by the PPO. After any visit, the policy holder must submit a claim, and will be reimbursed for the visit minus his/her co-payment. *This plan is available only to retirees permanently residing outside of the New England region.*

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**COVERAGE AGE 65 AND OVER**

Retired employees who are age 65 or over may elect, for themselves and their eligible dependents age 65 or over, any one of the plans Tufts University offers to individuals who are eligible for Medicare coverage. **Plan participants and eligible dependents must be enrolled in Medicare Part A and B coverage upon reaching age 65.** Individuals will be contacted once they become eligible for Medicare. Below is a brief summary of the health insurance plan options made available to you by Tufts University, if you are age 65 or older (the “Senior Health Plans”).

• **Senior Plans (Fallon HMO Premier, Tufts Health Plan Medicare Preferred)**

Tufts University offers a number of senior health maintenance organizations, which are designed to take the place of Medicare. When you enroll in one of these plans, you assign your Medicare Part A and B coverage to the HMO. Medicare pays the
HMO to provide health care to you. These senior HMO plans provide coverage for authorized medical treatment with small co-payments for office visits as well as for prescription drugs. **Note: You must reside within the service area at least six months of the year and your care must be directed by a primary care physician within the HMO’s network of providers.** You will be responsible for 100% of the cost of medical care that has not been provided or authorized by your primary care physician.

The benefits, limitations, conditions, exclusions, and other important information specific to each HMO are summarized in the applicable description of benefits, certificate of coverage, subscriber agreement, or evidence of coverage agreement issued by the HMO.

- **Medicare Supplement Plans (Blue Cross Blue Shield Medex Silver, Tufts Health Plan Medicare Complement, Harvard Pilgrim Medicare Enhance Preventive Plus)**

  These plans are designed to supplement your Medicare coverage by paying most of the prescription drug costs and most Medicare deductibles and coinsurance amounts. The Blue Cross Blue Shield and Harvard Pilgrim Plans allow you and your eligible dependents the freedom to choose your health care physicians as long as they are participating Medicare providers. The Tufts Health Plan requires that your care be directed by a primary care physician within the plan’s network of providers.

- **Medicare Part D**

  Medicare now offers a prescription drug benefit for eligible individuals who enroll and pay a premium for such benefit. Because you also receive prescription drug benefits through the Plan, you should compare your coverage under the Plan with the coverage you would receive if you enrolled in Medicare’s prescription drug benefit (Medicare Part D). You will be sent information on a yearly basis letting you know how prescription drug benefits under the Plan compare with Medicare’s prescription drug coverage. You must elect prescription drug coverage under Medicare D or enroll in one of the Tufts University Retiree Health Insurance Plans (which include prescription drug coverage); you cannot do both.

**DETAILED BENEFIT INFORMATION**

The details of each coverage option listed above are described in Insurance Booklets. The appropriate Insurance Booklet is provided to you automatically upon enrollment in a particular option, and the Booklets also are available upon request, free of charge. The Insurance Booklet will provide a schedule of benefits and inform you about any cost-sharing provisions, such as deductibles and co-payments; in-network and out-of-network benefits (including network providers); coverage of preventive services, drugs, diagnostic tests, medical procedures, and devices; any conditions or limits on emergency services or health care providers; pre-authorization or utilization review requirements; and other information that informs you about benefits in depth.
CHANGING HEALTH PLANS

In accordance with Medicare’s requirements, participants in the Senior Health Plans will be allowed to change their plan election only during the University’s annual Open Enrollment period, unless you will lose coverage due to moving out of your HMO’s service area. This same rule applies under the Plan to participants in the under-age-65 coverage options. You must contact the University’s Retiree Health Billing administrator at least 30 days prior to the date you want to make a change to your health plan.

EFFECTIVE DATE

Under-age-65 coverage for you and your eligible dependents will begin on your retirement date. Coverage at age 65 or over will begin on the first of the month following or coinciding with your retirement date or your (or your dependent’s) 65th birthday, whichever is later. (You or your dependent must be enrolled in Medicare Part A and B coverage to be eligible for the coverage for age 65 and over.)

COST

Tufts University currently shares the cost of coverage under the Retiree Health Insurance Plan with certain groups of retirees. Tufts University pays the difference, if any, between the contributions retirees make toward the cost of their coverage and the Tufts University cost of providing that coverage. Retirees who are not included in one of these groups pay the full cost of coverage.

Your contribution toward the cost of coverage (which is determined from time to time by Tufts University in its sole discretion) currently is as follows (this is in addition to all deductibles and co-payments, which are your responsibility):

<table>
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<tr>
<th>If you retired from Tufts University as of December 31, 1993 OR If you retired by June 30, 1994, and you provided Tufts University with formal written notice of your intent to retire by December 31, 1993:</th>
<th>If you (and your eligible dependents) are age 65 or over, coverage will be provided at no cost to you. (R93)</th>
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<td>If you (and your eligible dependents) are under age 65, you will pay the cost of your under-age-65 (active) coverage, less the Medicare supplement rate for the plan that corresponds to your active plan. In no event will the Medicare supplement rate be applied toward the cost of under-65 coverage for more than two members (you plus one eligible dependent). (R94)</td>
<td></td>
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<tr>
<td>If you met the age and service requirements for retirement on December 31, 1993, but you retire from Tufts University after June 30, 1994 OR If you retired by June 30, 1994, but did not provide the required formal written notice of intent by December 31, 1993:</td>
<td>You will pay the cost of the coverage you elect for both you and your eligible dependents, less the following amount: Tufts University’s Blue Cross Blue Shield MEDEX coverage rate in effect for 1994, increased by up to 2% for each year after 1994. In no event will the MEDEX coverage rate be applied toward the cost of coverage for more than two members (you plus one eligible dependent).</td>
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<tr>
<td>If you meet the age and service requirements for retirement on or after January 1, 1994, and you retire from Tufts University after June 30, 1994:</td>
<td>You will pay the cost of the coverage you elect for yourself, less the following amount: Tufts University Blue Cross Blue Shield MEDEX coverage rate in effect for 1994, increased by up to 2% for each year after 1994. You will also pay the entire cost of any coverage you elect for your eligible dependents.</td>
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<tr>
<td>If you were a full-time tenured faculty member of the Tufts University School of Medicine with at least ten years of service who would attain age 60 on or prior to September 30, 2007, and you elect to retire effective July 1, 2007:</td>
<td>You will not have to pay the cost of the coverage you elect for yourself but will have to pay the following amount: You will pay 50% of the cost of any coverage you elect for your eligible dependents.</td>
</tr>
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<td>If you were hired by Tufts University after December 31, 1993, and are not otherwise described above:</td>
<td>You and your eligible dependents may participate in the retiree health insurance coverage, if any, available to you when you retire. You will be responsible for the entire cost of the coverage you elect.</td>
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**CHANGES IN COST**

All costs, cost-sharing, rates, and working rates used by Tufts University for determining the contribution levels for retired employees for coverage under the Retiree Health Insurance Plan are subject to change from time to time. In addition, Tufts University reserves the right to change costs or cost-sharing and to eliminate its contributions at
any time. This is in addition to Tufts University’s right to amend or terminate this Plan in whole or in part at any time.

**WHEN COVERAGE ENDS**

Coverage for you and your eligible dependents under the Tufts University Retiree Health Insurance Plan ends on the earliest of the following dates:

- The date the Plan terminates;

- The date you cease to be eligible for coverage under the Plan (including, but not limited to, cessation of eligibility due to a Plan amendment or partial Plan termination);

- The date you fail to pay a required contribution for coverage by the applicable date. **There is no reinstatement of plan coverage due to non-payment of premium**;

- The date you voluntarily elect to discontinue your coverage under the Plan. **If you voluntarily elect to discontinue your coverage under the Plan, you cannot subsequently re-elect coverage under the Plan**;

- The date of your death; however, your eligible dependents will continue to be covered under the Plan, as long as they meet the Plan’s eligibility requirements and their coverage does not end for one of the reasons listed here; or

- If your dependents are no longer eligible for coverage because of a divorce, the ending of a domestic partnership, or if your dependent child reaches his or her 26th birthday; however, your affected dependent(s) may be eligible to continue coverage under COBRA for 36 months by paying the entire cost, plus an administrative fee, for coverage.

**CLAIM PROCEDURES AND APPEALS**

Under certain circumstances and depending on the health coverage option you choose, you may be required to file a claim form to obtain benefits. If you are required to complete a claim form for benefits, and any benefits under the plan are denied, you have the right to request a full and fair review of your claim within the timeframes set out in the claims procedures. If you believe you are incorrectly denied all or part of your benefits, you may appeal the health plan’s decision.

Please refer to your particular option’s Insurance Booklet for a description of the claim procedures and appeal processes for your retiree health insurance coverage.
SUBROGATION AND RIGHT OF REIMBURSEMENT

The purpose of the Plan is to provide retiree health coverage for qualified medical expenses that are not covered by a third party. If the Plan pays benefits for any claim you incur as the result of negligence, willful misconduct or other action or omission of a third party, the Plan will be subrogated to all your rights of recovery. Subrogation applies if you have a legal right to payment from an individual or organization because another party was responsible for your illness or injury. You will be required to reimburse the Plan for amounts paid for claims out of any monies recovered from a third party, including, but not limited to, your own insurance company as the result of judgment, settlement, or otherwise. In addition, you will be required to assist the Plan in enforcing these rights and may not negotiate any agreements with a third party or engage in any other conduct that would undermine the subrogation rights of the Plan.

In addition, the Plan is entitled to reimbursement of any claim paid for which you receive compensation from a third party, other than a family member, for medical expenses that have been paid by the Plan. This is true even if the payment you receive is described as payment for non-health care expenses, for example, attorney’s fees and expenses. If you do not provide the plan with necessary documents, your claim can be denied.

You must notify the Plan immediately if you begin settlement negotiations with or obtain a judgment against a third party in connection with an accident or injury for which benefits have been paid by the Plan. The Plan may offset any further payments by the amounts it was unable to recover from a third party who made payments in connection with an accident or injury.

COBRA

Under federal law, certain participants are entitled to continue coverage under the Plan in certain circumstances where coverage might otherwise end. When you and your dependents became eligible to participate in the Plan at the time of your retirement, you were given a choice between obtaining coverage under the Plan or obtaining COBRA coverage. Because you and your dependents elected to forego COBRA coverage at that time in lieu of coverage under the Plan, you and your dependents (in most cases) will not have the opportunity to elect COBRA if your participation under the Plan ceases in the future, since COBRA coverage has already been offered to you.

However, your eligible dependent may be able to elect COBRA and continue coverage for a limited period of time if your dependent experiences a qualifying event, such as divorce, legal separation, or if your dependent child reaches age 26, and loses coverage under the Plan. If such event occurs, you or your dependent must contact the University’s COBRA administrator within 60 days of the occurrence of such event. Once the University’s COBRA administrator has been notified, information regarding COBRA rights will be provided. If your dependent is eligible to elect COBRA coverage and wishes to do so, he or she must elect COBRA coverage within 60 days after the later of the date of the termination of coverage or the date the COBRA notice to elect to continue coverage is provided. The cost of COBRA coverage will be 100% of the cost.
of coverage, plus an additional 2% administration fee. Once COBRA is elected, your dependent will then have an additional 45 days to make the required initial payment for COBRA coverage. If COBRA continuation coverage is elected, it will continue for 36 months. However, COBRA coverage will end earlier than 36 months if your dependent becomes covered under another group health plan, becomes eligible for Medicare after electing COBRA, required premiums are not paid within 45 days of the due date (for the initial premiums) and within 30 days of the due date (for subsequent premiums), or the Plan is terminated.

**OTHER INFORMATION**

This section contains information provided to you by the Plan Administrator of the Plan to help you identify your plan and meet the requirements of the Employee Retirement Income Security Act of 1974. All inquiries relating to the following information should be referred directly to the Plan Administrator.

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Tufts University Retiree Health Insurance Plan</th>
</tr>
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<tbody>
<tr>
<td>Plan Number</td>
<td>602</td>
</tr>
<tr>
<td>Employer Number</td>
<td>04-2103634</td>
</tr>
</tbody>
</table>
| Plan Sponsor            | Tufts University  
                           | 200 Boston Avenue, Suite 1600  
                           | Medford, MA 02155  
                           | 617.627.3270 |
| Plan Administrator      | Tufts University  
                           | Vice President for Human Resources  
                           | 200 Boston Avenue, Suite 1600  
                           | Medford, MA 02155  
                           | 617.627.3271 |

The administration of the Plan is under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator has the discretion to determine all matters including, but not limited to eligibility, coverage, cost, and benefits under the Plan, and to determine all matters relating to the interpretation and operation of the Plan. Any determination made by the Plan Administrator shall be final and binding on all parties, in the absence of clear and convincing evidence that the Plan Administrator acted arbitrarily and capriciously.

The Plan Administrator has delegated day-to-day administration to the third-party administrators listed below, namely, the COBRA administrator for elections and enrollment, and the providers of the Plan health coverage options for benefits and claims. Notwithstanding the preceding paragraph, each provider of a Plan health coverage option has final discretionary authority to determine benefit claims and appeals with respect to participants and dependents covered by that option.
| Contract Administrators | COBRA/Retiree Health Billing Administrator  
Crosby Benefit Systems, Inc.  
27 Christina Street  
Newton, MA 02461  
617.928.0700  
800.462.2235  
servicecenter@crosbybenefits.com.  
  
Health Coverage Options  
Blue Cross Blue Shield of Massachusetts  
401 Park Drive  
Boston, MA 02215  
Fallon Community Health Plan  
10 Chestnut Street  
Worcester, MA 01608  
Harvard Pilgrim Healthcare  
93 Worcester Street  
Wellesley, MA 02481  
Tufts Health Plan  
705 Mt. Auburn Street  
Watertown, MA 02472  
  
Type of Welfare Plan | The Plan is a health insurance plan covering only eligible retirees and their dependents.  
  
Plan Year: | The Plan’s records are kept on a calendar year ending each December 31.  
The Plan year for the Employee Benefits Trust (described below) follows the fiscal year, July 1st-June 30th.  
  
Agent for Service of Legal Process | The Plan Administrator is the designated agent for service of legal process on the Plan. In addition, service of legal process may be made upon any Trustee of the Tufts University Employee Benefits Trust.  


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<tr>
<th>Section</th>
<th>Text</th>
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<tr>
<td>Employee Benefits Trust</td>
<td>The Plan is financed by contributions from the University and from Plan participants. Beginning June 1, 1994, amounts needed to pay premiums/benefits under the Plan, may, in the sole discretion of the Plan Sponsor, be paid from the University’s general assets or contributed to the Tufts University Employee Benefits Trust. The trustees of this trust are: Ann MacKenzie, Tufts University 200 Boston Avenue, Suite 1600, Medford, MA 02155 617.627.3270 Susan Leverone, Tufts University Tufts Administration Building, 169 Holland Street Somerville, MA 02144 Thomas McGurty, Tufts University Tufts Administration Building, 169 Holland Street Somerville, MA 02144</td>
</tr>
<tr>
<td>Limitation of Liability</td>
<td>With respect to any prepaid or insured coverage option or other part of the Plan, liability for providing benefits resides solely with the insurance carrier or other provider issuing the applicable prepaid contract or insurance policy. Tufts University has no liability for retiree health insurance benefits due or claimed under any such contract or policy.</td>
</tr>
<tr>
<td>Plan Amendment or Termination</td>
<td>Tufts University has established the Plan with the intention and expectation that it will be continued indefinitely, but Tufts University shall not have any obligation whatsoever to maintain the Plan for any given length of time. Tufts University shall at any time, at its discretion, amend or terminate the Plan, in whole or in part, with respect to any or all of its provisions, including but not limited to participants’ and/or beneficiaries’ benefits, or contributions. No vested rights of any nature are provided under the Plan.</td>
</tr>
<tr>
<td>Maternity-NMHPA</td>
<td>Group health plans and health insurance issuers offering group health 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, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).</td>
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</tbody>
</table>
YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a participant in the Tufts University Retiree Health 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:

- examine, without charge, at the Plan Administrator’s office, all plan documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room at the Employee Benefits and Security Administration;

- obtain copies of all documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500) and updated summary plan descriptions and other plan information upon written request to the Plan Administrator. 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 make available to each participant a copy of this summary financial report; and

- continue Group Health Coverage as described in this document.

In addition to creating rights for Plan participants, ERISA imposes duties upon 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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit from the Plan or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in 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 Plan Administrator's control.

If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan health coverage option, 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 Medical Child Support Order, you may file suit in federal court. If it should happen that the 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 you 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.

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 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, NW, Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (EBSA).

PROTECTING THE PRIVACY OF YOUR HEALTH INFORMATION

Under the Privacy and Security Regulations of the Health Insurance Portability and Accountability Act (“HIPAA”), the Plan is a “covered entity” and is subject to the requirements of the Privacy and Security Regulations published by the U.S. Department of Health and Human Services under HIPAA (the “Privacy Rule”), which place limits on how your health information may be used or disclosed. These include limits on how and when plan information may be shared with University, as the Plan Sponsor and your employer. The following provisions describe how the Plan may use and disclose your protected health information (“PHI”). These provisions are consistent with HIPAA’s Privacy Rule requirements. HIPAA and its implementing regulations were modified by the Health Information Technology for Economic and Clinical Health Act (“HITECH Act”), the provisions of which are incorporated herein by reference.

1. The Plan cannot use or disclose your PHI other than as permitted or required by this Plan or as permitted or required by the Privacy Rule. However, the Plan may use or disclose your PHI for the following purposes, provided that the Plan does not use or disclose more PHI than is necessary for the intended purpose:
(a) The Plan may use or disclose your PHI with your valid Authorization. For this purpose, an Authorization is your permission to use your PHI for a specific purpose or to disclose your PHI, for specific purposes, to another party.

(b) The Plan may use or disclosure your PHI without your Authorization for Plan administration purposes, treatment, payment, or health care operations.

   i. Payment includes activities by the Plan to determine or fulfill its responsibility to provide coverage and/or benefits to you.

   ii. Health care operations include activities to manage and operate the Plan, as defined by the Privacy Rule.

(c) PHI may be disclosed to another party, known as a “Business Associate,” such as Blue Cross and Blue Shield, if that other party agrees by contract to limit its use and disclosure of PHI to comply with the provisions of the Privacy Rule.

(d) Summary Health Information may be disclosed to the University, as the Plan Sponsor, for the purpose of obtaining premium bids for the Plan or for modifying, amending, or terminating the Plan. “Summary Health Information” is information that summarizes claims expenses and claims history and generally cannot be used to identify any particular member.

(e) PHI that does not identify any member may be disclosed for any purpose.

(f) The Plan may disclose to the University information on whether you are participating in the Plan (enrollment/disenrollment information).

2. Before the Plan discloses any PHI to the University, as Plan Sponsor, the University agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan, the Plan has been amended to incorporate the provisions set forth in Section 3 below and that the University agrees to comply with such provisions.

3. (a) The University agrees (i) to abide by the terms of the Plan regarding the permitted and required uses and disclosures of PHI and (ii) to comply with the Privacy Rule regarding the required use and disclosure of PHI.

   (b) The University shall ensure that any agent or subcontractor to whom it provides PHI received from the Plan agrees to abide by the same restrictions and conditions that apply to the University with respect to the PHI.

   (c) The University will not use or disclose PHI for employment-related actions or decisions or in connection with any of its other employee benefits or employee benefit plans, unless authorized by a member or otherwise permitted by the Privacy Rule.
(d) The University will report to the Plan any improper use or disclosure of PHI of which it becomes aware.

(e) The University will make PHI available to members so they may access their PHI and request that their PHI be amended in accordance with the Privacy Rule. Any amendments agreed upon will be incorporated into such PHI maintained by the University.

(f) The University will make PHI available in order to provide, upon request, an accounting of all disclosures of members' PHI for the immediately preceding six years, as provided under the Privacy Rule.

(g) The University will make available to the United States Department of Health and Human Services all of its practices, books, and records relating to the use and disclosure of PHI received from the Plan.

(h) If feasible, once the University no longer needs PHI for its intended purpose, the University will return the PHI to the Plan or destroy all copies of the PHI. If such action is not feasible, the University will limit further use and disclosure of PHI to those purposes that make the return or destruction of the information infeasible.

(i) The University will ensure that the adequate separation between the Plan and the University (i.e., the “firewall”), required by the Privacy Rule, is satisfied.

The University further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment 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 agree to implement reasonable and appropriate security measures to protect the information. The University will report to the Plan any security incident of which it becomes aware.

4. In order to maintain adequate separation between the Plan and the University, as Plan Sponsor and employer, employees in the following positions within the University will be the only employees who will have access to PHI received from the Plan for plan administration purposes:

(a) Employees working in the University's Benefits Office, or any other department involved in administration of the Plan, any Employee who has had Plan administration duties and responsibilities delegated to him/her by the Administrator, and any auditor, attorney or actuary, physician, vocational expert, or any other person or entity appointed to provide professional or administrative services to the Plan or to the Plan Sponsor in connection with the Plan.
(b) Such access to and use of PHI by these individuals is restricted to relevant Plan administration functions, including health care payment and operations and providing support for such functions.

(c) The University, as Plan Sponsor, shall establish an effective procedure for resolving any issues of noncompliance by any of the employees in the positions listed above in the event any such employee violates any of the provisions of this section.

The University will ensure that these provisions are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.