# Bentley University

# Employee Health & Welfare Benefit Plan
# Summary Plan Description

*This booklet, together with the separate benefit booklets provided to you by your employer that contain the specific details about your benefit coverages, constitute the Summary Plan Description for Bentley University Employee Health and Welfare Benefit Plan. Please read this booklet carefully and keep it along with your separate benefit booklets for future reference. If you require further information or have any questions, we encourage you to contact the Human Resources Office.*

Effective January 1, 2019

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## Introduction

This booklet presents basic information about all the health and welfare benefits provided by the Bentley University ("Bentley") Employee Health & Welfare Benefit Plan (the "Plan"), as of January 1, 2019, and your rights to benefits as a plan participant. The Plan is maintained for the benefit of eligible employees and their eligible dependents, and the purpose of the Plan is to provide medical, dental, life, and disability benefits to those individuals covered under the Plan.

This booklet and any separate benefit booklets provided to you by your employer together constitute the Summary Plan Description for your health and welfare benefits under the Plan, which is intended to comply with the disclosure requirements set forth in regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA) of 1974. Please refer to the applicable separate benefit booklets for complete details on specific items such as benefit coverage, definitions, coordination of benefits, waiting periods, exclusions and limitations.

On page 7 of this booklet the official Plan disclosures are provided for the Plan and other health and welfare benefit plans maintained by Bentley, along with the identity of the applicable Plan Sponsor, Plan Administrator, insurers and claims administrators (if any) and other important information specific to each of these benefits.

The Summary Plan Description is based on a number of legal documents that may include policies, contracts, collective bargaining agreements, plan documents and trust agreements. Although the Summary Plan Description is intended to be accurate, any differences between it and the legal documents will be governed by the legal documents.

## Eligibility and Benefits

Requirements regarding eligibility for participation and the conditions pertaining to eligibility to receive benefits are generally described on the attached Schedule A. Further requirements and conditions can be found in the separate benefits booklet for the applicable coverage.

## Benefit Claims

A claim for benefits is a request for a Plan benefit or benefits, made by a covered employee/dependent or his or her representative, that complies with the Plan's reasonable procedure for making benefit claims. A claim for benefits includes a request for a coverage determination, for pre-authorization or approval of a Plan benefit, or for a utilization review determination in accordance with the terms of the Plan. A claim for benefits should be filed with the applicable insurance carrier or third party administrator in accordance with the procedures set forth in the applicable benefits booklet issued by that insurance carrier or third party administrator and the attached Schedule B.

## Appealing a Denied Claim

If you have any questions about a claim payment, contact the insurance carrier, third party administrator, or the Plan Administrator. If you do not agree with the reason why your claim was denied, in whole or in

part, you should write to the insurance company or third party administrator that denied your claim, or to the Plan Administrator. Please refer to your benefits booklet and the attached Schedule B for a summary of applicable claim procedures and appeal processes.

Note that the Plan Administrator has full discretionary authority to control and manage the operation and administration of the Plan. For this purpose, the Plan Administrator's discretionary powers will include, but will not be limited to, interpretation of the Plan with respect to eligibility to participate, coverage and benefits under the Plan. The Plan Administrator may delegate this discretionary authority to an HMO, commercial insurance carrier or other third-party administrator.

*Any determination by the Plan Administrator, or any authorized delegate, shall be binding and final in the absence of clear and convincing evidence that the Plan Administrator or delegate acted arbitrarily and capriciously.*

## Loss of Benefits

The Plan Sponsor (Bentley), in its sole discretion, may at any time modify, amend or terminate the provisions, terms and conditions of the Plan without the consent of any participant or any beneficiary under the Plan. Any modification, amendment or termination of the Plan will be by a written instrument signed by an officer of the Plan Sponsor, or his or her authorized delegate, and delivered to the Plan Administrator. No vested rights of any nature are provided by the Plan.

Circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits are described in the attached Schedule A and in the separate benefit booklets.

NOTE: If you or any of your dependents lose coverage under the Plan, contact the Human Resources Office to determine what arrangements, if any, may be made to continue your group coverage or to convert to any available individual coverage. Certain rights to continue health care coverage are outlined on page 8.

## Sources of Plan Contributions

Contributions for certain coverages under the Plan may be made solely by the participating employers , or solely by participating employees. Some of the coverages require joint contributions from participating employees and participating employers.

## Third Party Liability

The Plan provides payment for covered expenses if you or your dependents are ill or injured. However, if a third party (person or organization) is at fault for the illness or injury and you or your covered dependents bring a claim against the third party, you must reimburse the Plan for any plan-paid benefits

immediately after you collect damages. The Plan will be reimbursed in full from any judgments, insurance policy proceeds or settlement before any amounts from such judgment, proceeds or settlements, including attorneys' fees you incur, are paid to any other person, regardless of the manner in which the recovery is structured.

The plan may file a lien against the third party, or the third party's agent or with the court, and you agree to consent to such lien. You must take any reasonable actions necessary to protect the Plan's subrogation and reimbursement rights, including notifying the Plan Administrator if and when you or your covered dependents file a lawsuit or other action or enter into a settlement negotiation with another party (including his or her insurance company) in connection with the conduct of such party. You must cooperate with the Plan's reasonable requests concerning its subrogation and reimbursement rights and must keep the Plan Administrator informed of any developments in any legal actions or settlement negotiations. You also agree that the Plan may withhold any future benefits paid by the Plan to the extent necessary to reimburse the Plan under its subrogation and reimbursement rights.

The Plan is subrogated to all the rights you may have against any third party, including an insurance company, liable for your injury or illness or for the payment for the medical treatment of such injury or illness up to the value of the benefits provided to you under the Plan. The Plan may assert its subrogation rights independently. You will cooperate with the Plan and its agents to protect these subrogation rights by, among other things, providing the Plan with relevant information that it requests, signing and delivering such documents as the Plan may reasonably require to secure its rights and obtaining the Plan's consent before releasing any party from liability for payment. Any litigation or settlement negotiations will be undertaken so as to not prejudice, in any way, the Plan's subrogation rights.

See your Evidence of Coverage and Disclosure booklet for details on your medical plan's right to recover benefits on behalf of you or your dependent.

## Your Rights Under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA)

**Receive Information About Your Plan and Benefits**

ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operations of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**Continue Group Health Plan Coverage**

You are entitled to continue health care coverage for yourself, spouse, domestic partner, or dependents if there is a loss of group health plan coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Bentley's group health plans include the medical/dental portions of the Bentley University Employee Health and Welfare Benefit Plan (Plan No. 514) and the Bentley University Health Care Reimbursement Plan (Plan No. 516).

Domestic partners are not considered qualified beneficiaries under COBRA. However, Bentley extends rights similar to COBRA to eligible Domestic Partners.

You should review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

**Prudent Actions by Plan Fiduciaries**

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

**Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such 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 Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan

fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees.

If you are successful the court may order the person 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.

**Assistance with Your Questions**

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

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**Additional Documentation**

The following documentation will be furnished without charge as a separate document by the Plan Administrator:

- upon request, a description of the Plan's procedures for Qualified Medical Child Support Orders;
- automatically, provider lists/directories for the applicable health provider networks utilized by the Plan; and
- automatically, claims procedures for medical and disability benefits to the extent such procedures change prior to the next revision of this Summary Plan Description.

## Agent for Service of Legal Process

The General Counsel of Bentley University has been designated as the agent for service of legal process. Legal process may be served upon the Plan at:

General Counsel
Bentley University
175 Forest Street
Waltham, MA 02452

Legal process may also be served on the Plan Administrator at the above address.

## Important Information About Your Plans

| *Plan Name and Number* | *Plan Sponsor & Identification Number* | *Plan Administrator & Agent for Legal Services* | *Plan Type, Administration & Plan Year End* | *Coverage Period End* | *HMOs, Insurers, or TPA* |
|---|---|---|---|---|---|
| Bentley University Employee Health and Welfare Benefit Plan (Plan No. 514) | Bentley University<br>175 Forest Street<br>Waltham, MA 02452<br>EIN #: 04-1081650 | Bentley University<br>175 Forest Street<br>Waltham, MA 02452<br>781-891-3427 | Medical<br>Insured<br>December 31 | Dec. 31 | Harvard Pilgrim Health Care<br>888-333-4742 |
| | | | Dental<br>Insured<br>December 31 | Dec. 31 | Delta Dental 800-872-0500 |
| | | | Basic and Optional Life Insured<br>December 31 | Dec. 31 | Lincoln Financial Group<br>1-800-210-0268 |
| | | | Core Long-Term Disability<br>Insured<br>December 31 | Dec. 31 | Lincoln Financial Group<br>1-800-210-0268 |
| | | | Accidental, Death and Dismemberment<br>Insured<br>December 31 | Dec. 31 | Lincoln Financial Group<br>1-800-210-0268 |
| | | | Employee Assistance Plan<br>Insured<br>December 31 | Dec. 31 | KGA, Inc.<br>800-648-9557 |
| | | | Vision<br>Insured<br>December 31 | Dec. 31 | EyeMed Vision<br>866-299-1358 |
| | | | Executive Long Term Disability Plan<br>Insured<br>December 31 | Dec. 31 | Standard Insurance Company<br>800-922-4446 |

## Continuation of Health Care Benefits - COBRA

A Federal law known as "COBRA" requires that most employers sponsoring group health plans offer employees and their families ("qualified beneficiaries") the opportunity to elect and pay for a temporary extension of health coverage called "continuation coverage" at group rates in certain instances ("qualifying events") where coverage under the employer's Plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of that law. (Both you and your spouse should take time to read this notice carefully.) If you are an employee of Bentley or one of the participating employers (the "Employer") covered by a group health plan maintained by Bentley (the "Health Plan"), you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by the Health Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the Health Plan for any of the following four reasons:

(1) The death of your spouse;

(2) Your spouse's separation from employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with the Employer; (3) Divorce or legal separation from your spouse; or

(4) Your spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by the Health Plan, he or she has the right to choose continuation coverage if group health coverage under the Health Plan is lost for any of the following five reasons:

(1) The death of the employee;

(2) The employee's separation from employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment with the Employer;

(3) The employee's divorce or legal separation;

(4) The employee becomes entitled to Medicare; or

(5) The dependent ceases to be a "dependent child" under the Health Plan.

Rights similar to those described above may, in certain instances, apply to retirees, spouses and dependents if Bentley is involved in a proceeding under Title 11, United States Code, and those individuals lose health coverage as a result of that proceeding.

Under the law, the employee or a family member has the responsibility to inform Bentley of a divorce, legal separation or a child losing dependent status under the Health Plan within 60 days of the later of the date of such event or the date on which coverage would be lost because of such event. Failure to do so within the time limits will result in loss of eligibility for COBRA continuation. Bentley has the responsibility to notify the Plan Administrator of the employee's death, separation from employment, reduction in hours or Medicare entitlement.

If you lose coverage because of a qualifying event, you have at least 60 days from the date you lost coverage to inform Bentley that you want to elect continuation coverage. If you do not elect continuation coverage on a timely basis, your group health coverage will end. If you elect continuation coverage, Bentley is required to permit you to elect and purchase coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Health Plan to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. This 18 months may be extended to 36 months from the date employment terminated or hours were reduced if a second event entitling you to choose continuation coverage (such as death, divorce, legal separation, ceasing to be a dependent child, or Medicare entitlement) occurs within that 18 month period.

The 18 months may be extended to 29 months if a qualified beneficiary is determined by the Social Security Administration (for purposes of Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act) to have been disabled at any time during the first 60 days of COBRA continuation coverage. This 11 month extension is available to all individuals who are qualified beneficiaries due to a termination in employment or reduction in hours. To benefit from this extension, the qualified beneficiary must notify Bentley of the Social Security Administration's determination within 60 days of such a determination and before the end of the original 18 month period of continuation coverage. The qualified beneficiary must also notify the Employer within 30 days of the date of any final determination by the Social Security Administration that the individual is no longer disabled. Furthermore, the monthly premium cost to such a qualified beneficiary during the 11 month extension will be increased to 150% of the applicable premium relating to continuation coverage.

A child who is born to or placed for adoption with the covered employee during a period of COBRA continuation coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Health Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA continuation coverage upon proper notification to the Plan Administrator within 60 days of the birth or adoption.

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

(1) Bentley no longer provides group health coverage to any of its employees;

(2) The premium for continuation coverage is not paid on a timely basis;

(3) The qualified beneficiary becomes covered -- after the date he or she elects COBRA coverage -- under any other group health plan (as an employee or otherwise);

(4) The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA coverage;

(5) The qualified beneficiary extends coverage for up to 29 months due to a disability and there has been a final determination that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose preexisting condition limitations. HIPAA coordinates COBRA's other coverage cut-off rule in (3) above with these new limits as follows:

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

You do not have to show that you are insurable to choose continuation coverage. However, as discussed above, you will have to pay all the required premiums for your continuation coverage.

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

The law also says that, at the end of the 18 month, 29 month or 36 month continuation coverage period, you must be allowed to enroll in an individual conversion health plan if such an individual conversion health plan is otherwise generally available under the Health Plan.

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

**Please note:** You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If You Have Questions About COBRA

If you have questions about COBRA continuation coverage, you should contact Sandra Smith or the current Benefits Specialist in the Human Resources Office, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA"). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of any Address Changes

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

Administration of COBRA/Contact Information

The Plan Administrator is responsible for administering COBRA. Notices that you are required to send to the Plan Administrator should be sent to Sentinel Benefits Group, P. O. Box 4004, Wakefield, MA 01880, to whom the Plan Administrator has delegated this responsibility.

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## Special Enrollment Periods – Health Insurance Portability and Accountability Act

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in one of the health care options offered by the Plan Sponsor if (a) the other coverage was COBRA coverage and such coverage was exhausted, (b) the other coverage is terminated due to your or your dependents' loss of eligibility, or (c) employer contributions toward such other coverage ceased, provided that, in all cases, you request enrollment within 30 days after the other coverage is exhausted or ends or after employer contributions cease. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption

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## Special Enrollment Periods – Children's Health Insurance Plan Reauthorization Act

Employees and their eligible dependents will be allowed to enroll in the Bentley University group health plan if one of the two following events occur:

(1) the employee's or dependents' Medicaid or State Children's Health Insurance Plan (SCHIP) coverage is terminated due to a loss of eligibility, or

(2) the employee or dependent becomes eligible for a premium subsidy under Medicaid or SCHIP.

Employees must request enrollment within 60 days of the effective date of the loss of Medicaid or SCHIP coverage or becoming eligible for the premium subsidy.

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## Maternity Stays – Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers 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 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 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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## Women's Health and Cancer Rights Act -- Reconstructive Surgery Following Mastectomies

A federal law known as the Women's Health & Cancer Rights Act of 1998 requires group health plans that provide coverage for mastectomies to provide mastectomy-related benefits to Plan participants:

Specifically, the legislation requires that when a covered individual receives benefits for a mastectomy and decides to have breast reconstructive surgery, the Plan and its insurance companies and HMOs must provide coverage in a manner determined in consultation with the attending physician and the patient, for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce symmetrical appearances; and
- prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

Coverage for the procedures will be the same as that for any other medical/surgical benefit under the medical plan you have elected, and certain general coverage limitations may apply including, but not limited to, deductibles, co-insurance, co-payments and reasonable and customary charges. Please refer to the description of your medical plan coverage in the schedule of benefits or other description for the medical plan you have elected.

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## Patient Protections under the Patient Protection and Affordable Care Act

Harvard Pilgrim Health Care generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Harvard Pilgrim Health Care at 1-888-333-4742 or visit www.harvardpilgrim.org.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Harvard Pilgrim Health Care or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a preapproved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Harvard Pilgrim Health Care at 1-888-333-4742 or visit www.harvardpilgrim.org.

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## Mental Health Parity and Addiction Equity Act of 2008 (MHPA)

If any health insurance option under the group health plan (1) provides for both medical and surgical mental health or substance use disorder benefits and (2) is not subject to an increased cost exemption (within the meaning of the MHPA):

- The health insurance option may not apply annual or lifetime limits for mental health or substance use disorders that are lower than those for medical and surgical benefits.
- The health insurance option may not apply more restrictive financial requirements or treatment limitations to mental health or substance use disorder benefits in any classification than the predominant limitations applied to substantially all of the medical and surgical benefits in any classification.
- The criteria for medical necessity determinations made under any health insurance option with respect to mental health or substance use disorder benefits shall be made available by the Plan Administrator (in accordance with the MHPA) to any current or potential participant upon request.
- The reason for any denial under the Plan or reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any Participant shall, on request or

as otherwise required under the MHPA, be made available by the Plan Administrator to the Participant in accordance with the claims procedures applicable to the group medical coverage feature.

- The Plan shall be operated and construed in all respects in compliance with the MHPA.

"Mental health benefits" and "substance use disorder benefits" shall be defined in the welfare benefit contract applicable to the health insurance option, pursuant to applicable state and Federal law, and consistent with generally recognized standards of current medical practice.

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## Summary of HIPAA Privacy Rights

A federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will require group health plans to protect the confidentiality of your private health information. The privacy and security provisions of HIPAA will apply to the medical/dental portions of the Bentley University Employee Health & Welfare Benefit Plan (Plan #514) and to the Bentley University Health Care Reimbursement Plan (Plan #516). These will be collectively referred to as the "Plans."

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

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

To the extent required by applicable law, the Plans will maintain a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact the Human Resources Office. If you have questions about the privacy of your health information, please contact the Human Resources Office or the designated privacy official.

## SCHEDULE A PLAN ELIGIBILITY REQUIREMENTS

### Employee Eligibility to Participate

A benefit eligible employee is a regular employee who is regularly scheduled to work at least 17.5 hours per week for at least nine months per year or a former employee who is continuing to receive benefits under this Plan pursuant to a severance arrangement with Bentley. The term "Benefit Eligible Employee"

includes an individual hired as an adjunct faculty member only for purposes of eligibility for the medical, dental and vision benefit options described under the Plan. The term "benefit eligible employee" includes an individual covered by a collective bargaining agreement with a Participating Employer if and only to the extent that the agreement provides for participation in this Plan. The term "benefit eligible employee" shall not include a temporary, relief, temporary agency or contract employee, or any other individual who is in a division, department, unit, or job classification designated by Bentley as not benefit eligible, except to the extent that such employee or individual must be treated as a Benefits Eligible Employee in order to avoid the imposition of an assessment under Code section 4890H(a), as determined by the Administrator in its sole discretion. Notwithstanding the foregoing, all Employees, except those individuals described in the immediate preceding sentence, will be considered Benefit Eligible Employees solely for the purpose of participating in the Bentley University Employee Assistance Program.

**Dependent Eligibility to Participate**

Benefit eligible employees who are enrolled for coverage under the Plan may enroll their eligible dependents for coverage, to the extent such coverage is available for such dependents and the dependents meet the eligibility criteria set forth in the applicable contract under which the benefits are available. Eligible dependents include the legal spouse (or domestic partner) and the dependent children of a benefit eligible employee. A child will be considered a dependent child if the child meets the requirements set forth in the applicable benefits booklet for the coverage to be provided.

## SCHEDULE B ERISA CLAIMS AND APPEAL PROCEDURES

**ERISA Claims Procedures For Health Claims**

**Claims for Benefits**

A claim for benefits is a request for a plan benefit or benefits, made by a covered employee/dependent or their representative, that complies with the plan's reasonable procedure for making benefit claims. A claim for benefits includes a request for a coverage determination, for pre-authorization or approval of a plan benefit, or for a utilization review determination in accordance with the terms of the plan.

*Post-Service Claims*

"Post-Service Claims" are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice from the Plan Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Plan Administrator will notify you within this 30 day period if additional information is

needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Plan Administrator will notify you of the denial within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

*Pre-Service Claims*

"Pre-Service Claims" are those claims that require notification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision (whether or not adverse) from the Plan Administrator within 15 days of receipt of the claim. If you filed a Pre-Service Claim improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 15 days of receipt of the pre-service claim. You will be given at least 45 days from the receipt of this notice to correct your claim.

The Plan Administrator will notify you of its determination within 15 days after the claim is received, unless the Plan administrator determines, in its discretion, that special circumstances require an extension of time for processing the claim. If an extension of time is required, a written or electronic extension notice indicating the special circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision shall be furnished to you prior to the end of the initial 15-day period. If the extension is necessary because of your failure to provide missing information and you are notified of that fact, the extension shall not exceed a period of 15 days beginning as of the earlier of (i) the date the missing information is received by the Plan Administrator or (ii) the end of the period afforded to you to provide the missing information. Otherwise, the extension shall not exceed 15 days from the end of the initial 15 day period.

If all of the needed information is received within the 45-day time frame, the Plan Administrator will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45 day period, your claim will be denied.

*Urgent Claims That Require Immediate Action*

"Urgent Care Claims" are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination (whether or not adverse) in writing or electronically as soon as possible, but not later than 72 hours after the Plan Administrator receives all necessary information, taking into account the seriousness of your condition.

If you filed an Urgent Care Claim improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional

information is needed to process the claim, the Plan Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Plan Administrator's receipt of the requested information; or
- The end of the 48 hour period within which you were to provide the additional information, if the information is not received within that time.

*Concurrent Care Claims*

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided by the Plan Administrator within 24 hours of the receipt of your request, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the Plan Administrator reduces or terminates such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments, the Plan Administrator shall notify you (sufficiently in advance of the termination or reduction to appeal the decision and obtain a determination upon review of the decision) before the course of treatment is reduced or terminated.

**Notice of Adverse Benefit Determination**

If a claim is wholly or partially denied, or if a rescission of coverage occurs (each, an "Adverse Benefit Determination") the Plan Administrator will furnish the Plan Participant with a written notice of the Adverse Benefit Determination. The written notice will contain the following information:

(a) the specific reason or reasons for the Adverse Benefit Determination;

(b) specific reference to those Plan provisions on which the Adverse Benefit Determination is based;

(c) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary;

(d) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review;

(e) In the case of an Adverse Benefit Determination by the Plan:

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request;

- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(f) In the case of an Adverse Benefit Determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

(g) In the case of an Adverse Benefit Determination, the Plan must:

- Ensure that any notice of Adverse Benefit Determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and provide notice of the opportunity to request (i) the diagnosis code and its corresponding meaning, and (ii) the treatment code and its corresponding meaning).

- Ensure that the reason or reasons for the Adverse Benefit Determination includes the denial code and its corresponding meaning, as well as a description of the group health plan’s standard, if any, that was used in denying the claim.

- Provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

- Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.

**Appeals of Claim Denials**

If you disagree with a claim determination after following the above steps, you can contact the Plan Administrator in writing to formally request an appeal. In your appeal, you may submit written comments, documents, records, and other information relating to your claim for benefits. You shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review of your claims shall take into account all comments, documents, records, and other information you submit, without regard to whether such information was submitted or considered in the initial benefit determination. With respect to a claim for benefits under a group health plan, the Plan will identify, upon request to the Plan Administrator, any medical experts whose advice was obtained on behalf of the Plan in connection with a your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card.  The date(s) of health care service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

You may appeal any denial of a claim within 180 days of receipt of such a denial by submitting a written request for review to the Plan Administrator.

The review of your appeal shall not afford deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

In the case of a claim involving urgent care, you are entitled to an expedited review process pursuant to which--

- You may submit a request for an expedited appeal of an adverse benefit determination orally or in writing; and
- All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Participant by telephone, facsimile, or other available similarly expeditious method.

The Plan must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the

Plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided (see Timing of Notification of Benefit Determination on Review, below) to give the claimant a reasonable opportunity to respond prior to that date.

Before the Plan can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided (see Timing of Notification of Benefit Determination on Review, below) to give the claimant a reasonable opportunity to respond prior to that date.

**Timing of Notification of Benefit Determination on Review**

For purposes of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted below due to a Participant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the Participant until the date on which the Participant responds to the request for additional information.

**Appeal Process**

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Plan Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You hereby consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

**Appeals Determinations**

***Pre-Service and Post-Service Claim Appeals***

You will be provided with written or electronic notification of the decision on your appeal as follows:

For appeals of Pre-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of Post-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with Urgent Claims, see "Urgent Claim Appeals That Require Immediate Action" below.

If you are not satisfied with the first level appeal decision of the Plan Administrator, you have the right to request a second level appeal from the Plan Administrator. Your second level appeal request must be submitted to the Plan Administrator within 60 days of the receipt of the first level appeal decision.

Please note that the Plan Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

***Urgent Claim Appeals That Require Immediate Action***

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your doctor should call the Plan Administrator as soon as possible. The Plan Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

The Plan Administrator has the exclusive right to interpret and administer the provisions of the Plan. The Plan Administrator's decisions are conclusive and binding. The Plan Administrator has final claims adjudication authority under the Plan.

**Manner of Notification of Final Internal Adverse Benefit Determination**

The Plan Administrator shall provide a Participant with written or electronic notification of a Plan's benefit determination on review. In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the Participant:

(a) The specific reason or reasons for the Adverse Benefit Determination;

(b) Reference to the specific Plan provisions on which the Adverse Benefit Determination is based;

(c) A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;

(d) A statement describing any voluntary appeal procedures offered by the Plan and the Participant's right to obtain the information about such procedures;

(e) A statement of the Participant's right to bring an action under section 502(a) of the Act; and

(f) The following information --

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Participant upon request;

- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

- The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

(g) In the case of an Adverse Benefit Determination the Plan must:

- Ensure that any notice of Final Internal Adverse Benefit Determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

- Ensure that the reason or reasons for the Final Internal Adverse Benefit Determination includes the denial code and its corresponding meaning, as well as a description of the group health plan’s standard, if any, that was used in denying the claim. This description must also include a discussion of the decision.

- Provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

- Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.

**External Review**

In the case of an Adverse Benefit Determination, you may be entitled to request an independent, external review of the decision. If your situation is urgent, you may be entitled to an expedited external review.

More information about your external review rights, including the timeframe and procedure for requesting an external review, will be provided to you in the Notice of Final Internal Adverse Benefit Determination.

## ERISA Claims Procedures For Disability Claims

**Manner and Content of Notification of Claims Decision**

The Plan Administrator will provide a claimant with written or electronic notification of the Plan's claims decision. If a disability claim is wholly or partially denied, the Plan Administrator will notify the claimant of the Plan's benefit determination within a reasonable time period, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the extension is necessary due to matters beyond the control of the Plan. After the expiration of the first 30 day extension of time, an additional 30 day extension may be necessary due to matters beyond the control of the Plan. If an extension or an additional extension is required, the Plan Administrator will notify the claimant in writing or electronically prior to the commencement of the extension or additional extension. The notice to the claimant will state the reason for the extension and the date by which the Plan expects to provide a decision. If the extension is necessary because the claimant failed to submit the information necessary to decide the claim, the notice of extension will describe the required information. The claimant then has 45 days from receipt of the notice within which to provide the specified information.

In the case of an adverse claims decision, the notification will include:

(i) The specific reasons for the adverse decision;

(ii) Reference to the specific Plan provisions on which the decision is based; (iii) A description of any additional material or information necessary for the claimant to complete the claim and an explanation of why that material or information is necessary;

(iv) A description of the Plan's review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action following an adverse claims decision on review;

(v) If an internal rule, guideline, protocol, or other criterion was relied upon in the decision-making, either (1) a copy of the rule, guideline, or protocol or (2) a statement that a copy of the rule,

guideline, or protocol will be provided free of charge to the claimant upon request; and (vi) If the adverse claims decision was based on a medical necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or (2) a statement that an explanation will be provided free of charge to the claimant upon request.

**Appeal of Adverse Claims Decisions**

Upon receipt of an adverse claims decision, the claimant (or the claimant's authorized representative) has up to 180 days to file an appeal with the Plan Administrator. The claimant may submit written comments, documents, records, and other information relevant to the claim for benefits. In addition, the claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

The appeal will be reviewed by an appropriate named fiduciary (the "reviewer") of the Plan who is neither the party who made the adverse claims decision that is the subject of the appeal, nor the subordinate of that party. The decision on appeal of an adverse claims decision will take into account all comments, documents, records, and other information submitted by the claimant (or the claimant's representative) relating to the claim, without regard to whether that information was submitted or considered in the initial claims decision. The appeal will not afford deference to the initial adverse claims decision.

**Notification of Claims Decision on Review**

The Plan Administrator will notify the claimant of the Plan's claims decision on review within a reasonable time period appropriate to the circumstances but not later than 45 days after receipt by the Plan of the claimant's request for review of an adverse claims decision. The 45 day period may be extended for another 45 days if the reviewer finds that special circumstances warrant an extension of time. If an extension of time is required, notice of the extension will be furnished to the claimant prior to the commencement of the extension.

**Manner and Content of Notification of Claims Decision on Review**

The Plan Administrator will provide claimants with written or electronic notification of a Plan's benefit determination on review. If the disability claim is wholly or partially denied on review, the Plan Administrator will provide the claimant with a written notification that will include:

(i) The specific reasons for the adverse decision;

(ii) Reference to the specific Plan provisions on which the claims decision is based;

(iii) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents and records relevant to the claimant's claim for benefits, without regard to whether those records were considered or relied upon in making the adverse

claims decision on review, including any reports, and the identifies of any experts whose advise was obtained;

(iv) A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about those procedures;

(v) A statement of the claimant's right to bring a civil action following an adverse claims decision on review; (vi) If an internal rule, guideline, protocol, or other criterion was relied upon in the decision-making, either (1) a copy of the rule, guideline, or protocol or (2) a statement that a copy of the rule, guideline, or protocol will be provided free of charge to the claimant upon request;

(vii) If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or (2) a statement that the explanation will be provided free of charge to the claimant upon request; and

(viii) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your Local U.S. Department of Labor Office and your State insurance regulatory agency."

**ERISA Claim Procedures For All Other Welfare Plans**

If your claim is wholly or partially denied, the Plan Administrator will provide you with a written notification which will include (i) the specific reasons for the denial, (ii) reference to the specific plan provisions upon which the denial is based, (iii) a description of any additional information necessary for you to perfect your claim with an explanation of why the information is needed, and (iv) a description of the plan's claim review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following a denial of benefits on review.

A written claim denial will be sent to you within 90 days after receipt of the claim by the plan. The 90 days may be extended for up to another 90 days if special circumstances warrant an extension of time. If such an extension is needed, you will be notified in writing prior to the end of the initial 90-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the plan expects to render a decision.

You, your beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review of your claim to the Plan Administrator. In connection with such a request, you may submit written comments, documents, records, and other information relating to your claim for benefits. You shall also be provided, upon request and free of charge, reasonable access to, and copies of, an documents, records and other information relevant to your claim for benefits.

A document, record, or other information shall be considered "relevant" to your claim if such document, record, or other information

(i) was relied upon in making the benefit determination;

(ii) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(iii) demonstrates compliance with the administrative processes and safeguards within these claims procedures in making the benefits determination.

The review of your claim will take into account all comments, documents, records and other information you submit relating to your claim, without regard to whether such information was submitted or considered in the initial determination of your claim.

You may have representation throughout the review procedure.

A request for a review must be filed within 60 days of your receipt of the written notice of denial of a claim. The full and fair review will be held and a decision rendered by the Plan Administrator no longer than 60 days after receipt of the request for review.

If there are special circumstances (such as the need to hold a hearing), the decision will be made as soon as possible, but not later than 120 days after receipt of the request for review. If such an extension of time is needed, you will be notified in writing prior to the end of the initial 60-day period.

The extension notice will indicate the special circumstances requiring an extension and the date by which a decision is expected to be reached. The decision with respect to your review will be provided in writing and will include specific reasons for the decision, specific references to the pertinent plan provisions on which the decision is based, a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits, and a statement of the claimant's right to bring an action under section 502(a) of ERISA.