SUMMARY PLAN DESCRIPTION

for

the Retiree Medical and Dental Benefits of the

Bentley University

Employee Health and Welfare Benefit Plan

Effective January 1, 2020

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This booklet, together with the relevant group insurance certificates and plan descriptions, constitute the Summary Plan Description (SPD) for the retiree medical and dental benefits provided under the Bentley University Employee Health and Welfare Benefit Plan (the "Plan") for eligible individuals who were first employed by Bentley College prior to January 1, 2000 and who subsequently retire from Bentley University.

The governing provisions of the Plan are set forth in the formal plan document and insurance policies issued by the insurance companies, which are available for your review upon request. In the event of a conflict between a statement in this Summary Plan Description and the Plan documents, the terms of the Plan documents will control. If after reading this summary you have any questions, please contact the Human Resources Office, who will direct you to the Plan Administrator.

Important Note

It is very important for you to recognize that your rights to the retiree medical and dental benefits described in this SPD and as provided under the Plan do not become vested after a certain period of time. The Board of Trustees of Bentley University, in accordance with applicable law, has the right to terminate or significantly alter the terms of the Plan for active and/or retired employees at any time for any reason. Of course, every effort will be made to communicate changes to you in a timely manner.

Introduction

Retirement usually means big changes in your life. It's a time of new opportunities, important decisions and adjustments in how you live your life every day. And if you're like most retirees, one of your biggest concerns is your medical care and benefits. Bentley University offers retiree medical and dental benefits to assist you with managing your medical care needs.

Over Age 65

If you are over age 65, the options available to you work together with Medicare Parts A and B. You should be sure to apply for your Medicare benefits about 90 days before you reach age 65 (or before you retire, if you retire after age 65), so that your Medicare coverage is effective as of your 65th birthday. Medicare Part A is generally referred to as hospital insurance and Part B is generally referred to as medical insurance. Contact the Social Security office nearest you for more information about how to apply for your Medicare benefits.

Need More Information About Medicare?

If you have Internet access at home, or if your public library offers Internet service, then you have lots of information at your fingertips. You can learn more about your Medicare benefits at this Internet address: http://www.medicare.gov.

If you don't have Internet access, you can get information about Medicare by calling 1-800-MEDICARE. You may also call your local Social Security or Medicare office. Just look under Social Security Administration or Medicare in the blue or government pages of your local phone book.

Plan Provisions

Eligibility

You are eligible for Retiree Medical and Dental Benefits if you:

- Were hired by Bentley College prior to January 1, 2000;
- Retire after age 60 with 10 years of full-time service with Bentley University;
- Have Bentley University medical coverage prior to retirement;
- Elect medical coverage when you retire in accordance with the Plan's guidelines, as outlined in this SPD; and
- Continue to timely pay your share of the cost of coverage, if applicable.

Coverage Levels

You may elect either coverage for yourself, or yourself and your spouse/domestic partner or other eligible dependent upon your retirement.

If you elect single coverage, you may not later add a dependent during the active plan year unless you experience a Qualifying Event. You may also add or change dependent coverage during the annual enrollment period each year.

Qualified Medical Child Support Orders

Your Bentley University active employee health plan is required by law to recognize a qualified medical child support order (QMCSO). A QMCSO is any court decree, judgment or order that creates or recognizes an alternative recipient -- such as your child or stepchild -- to be eligible under your active employee plan. If you were subject to a QMCSO before you retired and you were covering your dependent child under your Bentley University active employee health plan, contact the Human Resources Office for information about how to continue your child's coverage under COBRA or as a covered dependent.

Enrollment

To enroll, you and/or your spouse/domestic partner/other eligible dependents will need to meet with a Human Resources representative. You should enroll for your retiree medical and dental coverage about 30 days before you plan to retire.

Each year, you and/or your spouse/domestic partner/other eligible dependent will have the opportunity to change medical and dental coverage during the annual open enrollment period. If medical coverage is in place, you and/or your spouse/domestic partner/other eligible dependent may add dental coverage at any open enrollment period, if not initially elected. The University will notify you of this annual opportunity. Once you and/or your spouse/domestic partner/other eligible dependent drop medical coverage, you cannot re-enroll. Dental coverage may continue if medical coverage is no longer in place. However, once you drop dental coverage you may not re-enroll.

Over Age 65 at Retirement

If you or your spouse is age 65 or older, you should be sure to first enroll for Medicare Parts A and B. Then you can complete the necessary enrollment applications with Bentley. A copy of your Medicare card will be required to complete your enrollment.

You will be informed of your choices to enroll in either a Bentley-approved Medicare + Choice plan or Bentley-approved Medicare supplement as well as Bentley University's contribution amount and the amount of your share of the costs.

Under Age 65 at Retirement

If you are younger than age 65, you will be informed by Bentley about how to arrange your on-going payment for continued medical coverage until you become Medicare-eligible (by virtue or reaching age 65 or as a result of disability). Your spouse, domestic partner or other eligible dependents may continue to be covered under your medical coverage. If, however, your spouse is over age 65 at your retirement, he or she must enroll in Medicare Part A and Part B when you retire. Your spouse will be informed of his or her choices to enroll in either a Bentley-approved Medicare + Choice Plan or Bentley-approved Medicare Supplement. In order to preserve any special enrollment

rights and avoid any potential Medicare premium penalties, your eligible domestic partner must enroll in Medicare as soon as he or she turns age 65, regardless of whether or not you have retired. Upon your retirement, your domestic partner will be informed of his or her choices to enroll in either a Bentley-approved Medicare + Choice Plan or Bentley-approved Medicare Supplement.

When Coverage Begins

Your retiree medical and/or dental coverage (and that of your spouse/domestic partner/other eligible dependents) will begin on the first day of the month following your retirement date, provided you have complied with the application process.

When Coverage Ends

For You

Your coverage will end at the earliest of the following dates:

1) The date you fail to pay the required premium ;

2) The date you elect in writing to discontinue coverage;

3) The date you die; or

4) The date Bentley University terminates the plan.

For Your Spouse/Domestic Partner or Other Covered Dependent

If your spouse/domestic partner, or other covered dependent is covered under this plan, coverage for your dependents will end at the earliest of the following dates:

1) The date you (or your spouse/domestic partner/other covered dependent) fail to pay the required premium;

2) The date your spouse/domestic partner/other covered dependent) elect to discontinue coverage;

3) The date you die;

4) The date your spouse/domestic partner or other covered dependent dies;

5) The effective date of a divorce or dissolution of domestic partnership after the employee has elected the retiree coverage: or

6) The date Bentley University terminates the plan.

Your Retiree Medical And Dental Benefits

The following sections outline the retiree medical benefits provided under this Plan.

If You, Your Spouse/Domestic Partner, or Other Covered Dependent Is Under Age 65

If you are under age 65 and retired (regardless of your spouse's/domestic partner's or other dependent's age), you are not yet eligible for Medicare. In this case, you may remain covered under the same Bentley University plan under which you had coverage when you were an active employee. When you reach age 65 or otherwise become Medicare-eligible, you must enroll for over-age 65 benefits which become effective the first day of the month in which you turn age 65. If your spouse/domestic partner, or other covered dependent is under age 65, the same rules would apply to him or her, regardless of your age.

For information about coverage, exclusions, costs and other important provisions under these plans, refer to your health care plan's materials, which will be supplied to you by your heath plan upon enrollment, or as plan changes occur.

If You or Your Spouse/Domestic Partner, Are Age 65 or Older

Since you and/or your over age 65 covered spouse / domestic partner are eligible for Medicare, you and/or your over age 65 covered spouse/domestic partnermay choose to:

- Enroll in one of the Bentley-approved Medicare + Choice plan(s) explained later in this section; or

- Enroll in one of the Bentley-approved Medicare supplement(s) explained later in this section.

Each year during the annual open enrollment period, you will have the opportunity to change your election. For example, if you are currently enrolled in a Bentley-approved Medicare + Choice plan and you would like to enroll in a Bentley-approved Medicare supplement you may make that change during open enrollment.

Here is how the two options work.

Medicare + Choice Plans and Medicare Supplements

You may select from among the following Medicare + Choice plans and Medicare Supplements:

Medicare + Choice plans

- Medicare Preferred HMO (Tufts Health Plan)

Medicare Supplement

- Medex II (Blue Cross BlueShield of Massachusetts)
- Medicare Preferred Prime Supplement (Tufts Health Plan)

Please note that Bentley University reserves the right to add or drop Medicare supplements and/or Medicare + Choice plans from the available choices mentioned above for a particular plan year. You will be notified of any changes in sufficient time for you to choose your plan before the start of the plan year for which the changes will take effect.

Upon your initial enrollment in one of these plans, you will be provided with a detailed description providing information on coverage, exclusions, costs, claim and appeal procedures and other important provisions from the applicable insurance carrier.

Costs

You and Bentley University share in the cost of retiree medical coverage. Depending on the date you retired, your share of the costs will vary as explained below. If your spouse qualified as a Bentley retiree when he or she retired but elected to be covered under your family plan while you were still employed, when you retire, your spouse can elect Retiree Medical coverage at the Retiree cost in effect at the time of your retirement. Dental coverage is available at the COBRA rate, which is the full premium cost plus a 2% administrative fee.

What Bentley University Pays

The amount of the maximum monthly contribution Bentley University will pay towards your retiree medical coverage depends on your age and when you retired as follows:

Retirees Under Age 65

- For a Retiree Participant who retires on or after July 1, 2004, Bentley will contribute the following monthly maximum for the **2020** Plan Year:

	Individual	Ind + spouse	Ind + child(ren)	Family
Harvard Pilgrim HMO	$127.97	$503.28	$503.28	$503.28
Harvard Pilgrim Best Buy HMO	$127.97	$494.87	$494.87	$494.87
Harvard Pilgrim HDHP	$127.97	$494.21	$494.21	$494.21

In future years, these amounts may be changed in Bentley's sole discretion. Notwithstanding the above, the Retiree Participant is responsible for paying the full cost of coverage for: 1.) his or her spouse/domestic partner and/or other eligible dependents that remain covered under one of the above plans after the Retiree Participant becomes eligible for Medicare and 2.) any spouse/domestic partner covered under a Bentley-approved Medicare + Choice Plan or Bentley-approved Medicare Supplement Plan.

Retirees Age 65 or Older

- Bentley will pay the full cost of individual coverage for Retiree Participants who retired prior to January 1, 1996.

- Bentley will contribute the following monthly maximums toward individual coverage for a Retiree Participant who retired on or after January 1, 1996 and before July 1, 2004.

BCBS Medex II	$208.98
Tufts Medicare Preferred HMO	$150.75
Tufts Medicare Preferred Prime Supplement	$216.50

- For a Retiree Participant who retires on or after July 1, 2004, Bentley will contribute the following monthly maximum towards individual coverage for the **2020** Plan Year:

BCBS Medex II	$130.88
Tufts Medicare Preferred HMO	$55.71
Tufts Medicare Preferred Prime Supplement	$127.72

In future years, these amounts may be changed in Bentley's sole discretion.

The Retiree Participant is responsible for paying the full cost of coverage for his or her spouse/domestic partner and other eligible dependents.

Please note: The amounts described above, as they may change from time to time, are maximum contribution amounts. In no event will Bentley pay more than the actual monthly cost of coverage if such cost is less than the maximum contribution amount described above.

What You Pay

You will be responsible for paying the difference between the University's contribution and the total premium. Each year you will be notified of your share of the premium cost.

You pay your share of the premiums by sending a check payable to Bentley University, Care of Sentinel Benefits & Financial Group. You may send your check monthly with the appropriate coupon to:

Sentinel Benefits & Financial Group
P.O. Box 4004
Wakefield, MA 01880

1-888-762-6088

www.sentinelgroup.com

Payment should be made
payable to: Bentley
University

You must pay your share of the premiums prospectively. Your check must arrive by the first of the month that your payment covers. In other words, your check for September coverage must arrive by September 1st. If you fail to pay the required amount, your coverage under this plan will end.

Summary of Benefits

If you are covered under a Medicare + Choice plan, a summary of the benefits provided under each Medicare + Choice plan is set forth in the applicable certificates of insurance, HMO booklet or other documentation issued by the insurance company that insures such benefit. Upon request, you or your covered beneficiary may obtain free of charge a detailed schedule of benefits for the Medicare + Choice plans.

If you are covered under a Medicare supplement, the benefits under that plan are coordinated and supplement the benefits you receive under Medicare. Medicare benefits are described in the handbook entitled "Medicare & You" which is issued to you by the

Center for Medicare & Medicaid Services. A description of the supplemental benefits provided under each Medicare supplement is set forth in the applicable certificate of

insurance or other documentation issued by the insurance company that insures the benefits. Upon request, you or your covered beneficiary may obtain free of charge a detailed schedule of benefits for the Medicare supplement plan.

The documents described above also inform you of the circumstances under which benefits may be terminated, reduced or denied.

How to File a Claim

In many cases, you may not need to file a claim form. You may be required to file claim forms in some cases, however. See your plan's materials issued by the insurance companies for information about claim filing procedures.

Claims Procedures

The procedures for filing claims for benefits, including the time limits for presenting claims, are set out in the respective plan's materials issued by the insurance companies. With respect to claims for benefits under a Medicare supplement, the insurance company will follow the decisions made by Medicare on your Medicare-provided benefits.

The insurance company that insures the benefits under the Plan is the named fiduciary for purposes of determining the amount of and entitlement to benefits under the Plan. Such insurance company has the exclusive responsibility and authority to administer and interpret the Plans and make conclusive and binding determinations on questions of eligibility and entitlement to benefits. All decisions regarding payment or nonpayment of benefits under the Plan will be made by the appropriate insurance company in accordance with its reasonable claims procedures as required by ERISA.

Claims Review Procedures

You will receive written notification from the insurance company if your claim is denied in whole or in part. The notification will tell you the reason(s) why your claim was denied and describe the procedure for appealing the denial.

If you are covered under a Medicare + Choice plan, see the certificate of insurance or other benefit description issued by the insurance company for more information about how to file a claim and for details regarding the applicable claims procedures.

If you are covered by a Medicare supplement, the appeals process for benefits under the Medicare supplement will follow the procedures set up by Medicare for your Medicare benefits. These procedures are described on the back of each Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from the company that handles bills for Medicare.

Since this Plan will follow the provisions under the Medicare system it is unlikely that you would need to appeal a denied claim to the Claims Administrator. Bentley University, as the Plan Administrator, arbitrates eligibility appeals only. However, in the event a claim arises ERISA provides you with the following claims appeals rights:

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 our 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.

Continued Coverage Under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your eligible dependents ("qualified beneficiaries") may continue Plan coverage if that coverage would otherwise end under certain circumstances (called "qualifying events"). Qualified beneficiaries may continue coverage for a certain period of time by paying the full plan cost plus an administrative charge.

Each qualified beneficiary has an independent right to elect continued coverage under COBRA without providing proof of good health. The qualified beneficiary must elect continued coverage under COBRA no later than 60 days after the date of the COBRA eligibility notice. If the qualified beneficiary does not elect continued coverage within this 60-day period, he or she forfeits his or her right to continued coverage (see Electing Continued Coverage for more information).

Your spouse, your eligible dependents and any children born to or placed for adoption with a qualified beneficiary during a period of COBRA continuation coverage are qualified beneficiaries for purposes of coverage under COBRA.

Continued Coverage

Your covered spouse and/or eligible dependents may continue their coverage for up to 36 months if they lose coverage under the terms of the plan because of one of the following qualifying events:

- You (the retiree) and your spouse become divorced or a judgment of separate maintenance or legal separation (if applicable under state law) is entered;
- You die; or
- Your covered dependent child no longer meets the plan's definition of a dependent (for example, if a dependent child reaches the maximum age limit for coverage).

In addition, if the Company files for a Chapter 11 bankruptcy and you lose coverage within one year before or after the bankruptcy filing, you and your covered spouse and dependents may elect to continue coverage.

In such case, coverage for you may continue until your death. Coverage for your spouse and dependent children may continue for 36 months following your death (or upon their respective deaths, if earlier).The cost of continued coverage will be 102 percent of the cost of coverage for retirees.

You or your covered family members must notify a Human Resources Representative of divorce, legal separation, or of a dependent ceasing to qualify as an eligible dependent within the later of 60 days of the applicable qualifying event or 60 days of the date coverage would otherwise end because of the event. A qualified beneficiary may also elect COBRA continuation coverage for an eligible child who is born to, adopted by, or placed for adoption with the qualified beneficiary while your COBRA continuation coverage (or right to elect COBRA continuation coverage) is effective, provided that he or she notifies the Plan Administrator in writing within 31 days of the child's birth, adoption, or placement for adoption.

If you or your covered family members do not notify Bentley University in a timely manner, as described above, the qualified beneficiaries will not be eligible to elect

continued coverage under COBRA. Notice of any right to continued coverage to a covered spouse will be deemed notice to any covered dependent children who reside with your spouse.

Once notification has taken place, the qualified beneficiary will receive a notification package. This package will contain details about continuing coverage, such as the deadline for electing continued coverage, monthly costs, and how to pay for coverage.

SUMMARY OF COVERAGE OPTIONS UNDER COBRA	
Continued coverage is available if coverage would otherwise be lost because:	For up to:
Your dependent child is no longer eligible under the plan	36 months for your dependent child
You divorce or legally separate from your spouse	36 months for your spouse and eligible dependent children
You die	36 months for spouse and dependent children
Bentley University files for bankruptcy	Until your death for you 36 months following your death for your spouse and eligible dependent children

Electing Continued Coverage

Once a qualifying event occurs and a qualified beneficiary has been notified of the right to continue coverage, the qualified beneficiary has 60 days in which to elect continued coverage. This 60-day period begins on the later of the date:

- The qualified beneficiary would lose coverage because of the qualifying event, or

- The qualified beneficiary is advised by the Plan Administrator of the right to continued plan coverage.

The first premium payment must be made within 45 days after the date the election notice is completed. The initial premium payment must cover the entire period from the date of the qualifying event to the date of your payment.

If the first payment is not received within 45 days, the qualified beneficiary will be considered to have forfeited the right to continued plan coverage with respect to the qualifying event to which the election pertained, and the individual's coverage under the plan will be terminated as of the date of the qualifying event. If the amount of any subsequent payment is not received within 30 days after the first day of the calendar month for which such payment is due, coverage under the plan will be terminated as of that date. There is no reinstatement provision under the plan's COBRA provisions.

When COBRA Coverage Ends

COBRA continued coverage will end for each qualified beneficiary on the earliest of the date:

- The qualified beneficiary fails to pay any required premium within the stated grace period;
- The qualified beneficiary first becomes covered (after the COBRA election) as an employee or dependent under any other group health plan;
- The qualified beneficiary first becomes entitled to Medicare after his or her COBRA election;
- Bentley University ceases to provide any group health plan to any employee;
- The maximum COBRA continuation period expires.

The Plan Administrator shall adopt such rules for the administration of these COBRA provisions as it deems necessary and appropriate from time to time. Continuation of

coverage is provided subject to eligibility under the law. The Plan Administrator reserves the right to terminate continuation of coverage retroactively for any qualified beneficiary who is determined to be ineligible for continued coverage.

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.

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). ERISA provides that all plan participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites 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 operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Descriptions. The administrator may make a reasonable charge for the copies.

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer 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

In accordance with the Appeal Process described in this SPD and the Plan, 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 administrator's control.

If you have a claim for benefits, which is denied after all required appeals have been made 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 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 Benefits 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 Benefits Security Administration.

In Massachusetts, you can reach the Department of Labor at:

U.S. Department of Labor
Employee Benefits Security Administration
One Bowdoin Square
7th Floor
Boston, MA 02114
(617) 424-4950

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.

Maternity and Childbirth

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 caesarean 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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.

Certification of Medical Coverage

Your medical plan will provide you and/or your covered dependents with a coverage certificate promptly after your coverage under Bentley's Plan ends. If you elect COBRA continuation coverage, you will also receive a coverage certificate after COBRA coverage ends. Keep a copy of the coverage certificate(s) you receive, as you may need to prove you had prior coverage if you join a new plan sponsored by another employer or enroll in an individual health insurance plan. You and/or your dependents, or someone on your behalf, may also request a coverage certificate within 24 months of the date your medical coverage ended. ***If you would like to request a copy, please contact Harvard Pilgrim Health Care Member Services Department at 1-888-333-4742.***

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 retiree medical and dental benefits of the Bentley University Employee Health & Welfare Benefit Plan (Plan #514).

The Plan and Bentley, as plan sponsor of the Plan, 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 Plan will require all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of 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 Plan 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.

Network Providers

Some or all of the underlying insurance contracts which provide benefits under this Plan require you to obtain services through their provider network. A complete listing of all

providers including physicians, hospitals, and other health care facilities is furnished automatically to you without charge as a separate document.

Amendment or Termination of the Plan

Bentley University makes no promise to continue these benefits in the future and rights to plan benefits will never vest. Retirement does not give any retiree any vested right to continue plan benefits, and the University may impose or increase required retiree contributions to the Plan.

The Board of Trustees of Bentley University shall have the sole right at its discretion to modify, amend, or terminate the plan described in this SPD in whole or in part at any time and from time to time and in any manner it may deem advisable, as evidenced by a written instrument adopted by the Board of Trustees, subject to the terms of the Plan and applicable law.

In the event of the modification, amendment, or termination of a plan, the rights of persons covered by the plan at that time shall be limited to the benefit claims incurred as of the date the plan is modified, amended or terminated.

Plan Administrative Information

Plan Name: The plan is known as the Bentley University Employee Health and Welfare Benefit Plan.

Plan Identification Number: Bentley University has assigned number 514 as the plan identification number.

Plan Year: The plan year is the period on which the plan maintains its records. The plan year is the calendar year, starting January 1st of every year and ending the following December 31st.

Type of Plan, Funding and Type of Administration: The plan is a fully-insured group medical plan and is funded out of the University's general assets. Retirees may also

contribute to the cost of coverage. The Plan is administered by the applicable insurance company.

Plan Administrator: Bentley University is the Plan Administrator. The University has designated the Human Resources Office to assist with plan administrative duties. You may contact the Human Resources Office by calling (781)-891-3427 during normal business hours or by writing:

Executive Director
Human Resources Office
Bentley University
175 Forest Street
Waltham, MA 02452

The Plan Administrator is responsible for providing you and other participants with information regarding your rights and benefits under the plan. The Plan Administrator also has the primary authority for filing the various reports, forms and returns with the Department of Labor and the Internal Revenue Service.

Plan Sponsor: Bentley University is the plan sponsor. You may reach the plan sponsor at:

Human Resources Office
Bentley University
175 Forest Street
Waltham, MA 02452

Employer Identification Number: Bentley University's employer identification number ("EIN") is: EIN:04-1081650.

Agent for Service of Legal Process: The General Counsel of Bentley University has been designated as the agent for service of legal process. A processor may serve legal process upon the plan at:

General Counsel
Bentley University
175 Forest Street
Waltham, MA 02452

Process may also be served upon the Plan Administrator at the address indicated above.

Retiree Health Plan Addresses: Following are the addresses and telephone numbers for the Bentley-approved retiree medical and dental plans:

Under Age 65 and Non-Medicare Eligible

Harvard Pilgrim HMO
Harvard Pilgrim Best Buy HMO
Harvard Pilgrim HDHP
Harvard Pilgrim Health Care
93 Worcester Street
Wellesley, MA 02481 1-888-333-
4742www.harvardpilgrim.org/bentley

Delta Dental Premier
Delta Dental of Massachusetts
465 Medford Street
Boston, MA 02129-1454
1-800-872-0500
www.deltadentalma.com

Age 65 and Over or Medicare-Eligible

Tufts Medicare Preferred Prime Supplement
Tufts Medicare Preferred HMO
Tufts Health Plan
705 Mt. Auburn Street
Watertown, MA 02472
1-800-936-1902
www.tuftshealthplan.com
www.tuftsmedicarepreferred.org

BlueCross and BlueShield of Massachusetts, Inc.
Attn: Medex II
Landmark Center
401 Park Drive
Boston, MA 02215-3326
1-800-882-1093
www.bluecrossma.com

In the event Bentley University changes Bentley-approved Medicare + Choice plans or Medicare supplements for a Plan Year, you will be notified as soon as administratively practical of the new plans and of the addresses and telephone numbers of the applicable insurance companies.