

**SOUTHWESTERN UNIVERSITY  
RETIREE HEALTH REIMBURSEMENT  
ARRANGEMENT**

**Summary Plan Description**

**Effective January 1, 2014**

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## PLAN INFORMATION APPENDIX

## INTRODUCTION

Southwestern University (the “Employer”) has established the Southwestern University Retiree Health Reimbursement Arrangement (the “Plan”) for the benefit of Eligible Retirees and their Eligible Spouses or Eligible Domestic Partners (“Participants”). The purpose of the Plan is to reimburse Participants for Medicare Supplemental Plan premiums and Eligible Medical Expenses, which are not otherwise reimbursed. The Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended (“Code”), as well as a health reimbursement arrangement as defined in Notice 2002-45, published by the Internal Revenue Service.

This summary plan description (this “SPD”) contains the material provisions of the Plan. In the event of any conflict between the terms of this SPD and the terms of the Plan document, the terms of the Plan document will control. Participants seeking to obtain additional information about the Plan should contact the Employer.

Note that capitalized terms used in this SPD are defined the first time they are used or are defined in the Plan Information Appendix at the end of this booklet. Please note that “you,” “your” and “my” when used in this SPD refer to you, the Participant.

## PART I GENERAL INFORMATION ABOUT THE PLAN

### **Q-1. What is the purpose of the Plan?**

The purpose of the Plan is to reimburse Participants (as defined in Q-2 and Q-3) for Eligible Medical Expenses (as defined in Q-5) which are not otherwise reimbursed by any other plan or program. Reimbursements for Eligible Medical Expenses paid by the Plan generally are excludable from the Participant’s taxable income.

### **Q-2. Who can participate in the Plan?**

Eligible Retirees and their Eligible Spouses or Eligible Domestic Partners are eligible to participate in the Plan if they meet all requirements to be an Eligible Retiree, Eligible Spouse or Eligible Domestic Partner as defined in Section 1 of the Plan Information Appendix. Eligible Retirees, Eligible Spouses and Eligible Domestic Partners who become covered under the Plan, as explained in Q-3, are called “Participants.”

### **Q-3. When do I actually become a Participant in the Plan?**

An Eligible Retiree, Eligible Spouse or Eligible Domestic Partner becomes a Participant in the Plan on the later of the Effective Date of the Plan as provided in the Plan Information Appendix or the date that he or she has satisfied all of the following requirements:

- Is enrolled continuously in the Southwestern University Group Health Plan (the “Health Plan”) from the date of the Eligible Retiree’s retirement until age 65, or, if later, the date he or she is first otherwise eligible to participate in the Plan;
- Is Eligible for Medicare or a similar government-sponsored retiree health plan;
- Is enrolled in Medicare Part B or a similar government-sponsored retiree health plan;

- Is enrolled in an individual Medicare Supplemental Policy, including Medicare Part D; and
- Completes all enrollment forms or procedures required by the Plan Administrator.

**Q-4. How does the Plan work?**

One HRA Account will be established for each Participant, except that married Participants and Participants who are Domestic Partners shall share a combined HRA Account with their spouse or Domestic Partner. This means that Benefit Contributions for each Eligible Retiree and Eligible Spouse or each Eligible Retiree and Eligible Domestic Partner will be credited to a single HRA Account.

Contributions will be credited to HRA Accounts by the Employer on or about each January 1, or the date in which the Participant first becomes enrolled in the Plan. Beginning January 1, 2014 through December 31, 2018, it is anticipated that the contribution amount shall equal the average Medicare Supplemental Plan L and Medicare Part D premiums in Travis and Williamson Counties (determined by age and gender, in single-year increments). Beginning on January 1, 2019, it is anticipated that the contribution amount shall be capped at the 2018 average premiums. The Employer may change the contribution amount at any time in its sole discretion.

Your HRA Account will be reduced from time to time by the amount of any Eligible Medical Expenses for which you are reimbursed under the Plan. At any time, you may receive reimbursement for Eligible Medical Expenses up to the amount in your HRA Account. Note that the Internal Revenue Code does not permit Participants to make any contributions to their HRA Accounts.

The HRA Account does not bear interest or accrue earnings of any kind. All benefits under the Plan are paid entirely from the Employer's general assets.

**Q-5. What is an "Eligible Medical Expense"?**

An Eligible Medical Expense is an expense incurred by a Participant for medical care, as that term is defined in Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment or prevention of disease). Some common examples of Eligible Medical Expenses include:

- Premiums for medical, prescription drug, dental, vision or long-term care insurance.
- Medications (in reasonable quantities) **NOTE:** Medications are considered Eligible Medical Expenses only if they are prescribed by a doctor (without regard to whether the medication is available without a prescription) or are insulin.
- Uninsured Medical Expenses (i.e., copayments, coinsurance, deductibles).
- Dental expenses;
- Dermatology;
- Physical therapy;
- Contact lenses or glasses used to correct a vision impairment;
- Chiropractic expenses;
- Hearing aids; and

- Wheelchairs.

Some examples of common items that are **not** Eligible Medical Expenses include:

- Long-term care services;
- Cosmetic surgery or similar procedures
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy;
- Custodial care; and
- Health club or fitness program dues.

If you need more information regarding whether an expense is an Eligible Medical Expense under the Plan, contact the Third Party Administrator as provided in the Plan Information Appendix.

Only Eligible Medical Expenses incurred while you are a Participant in the Plan may be reimbursed from your HRA Account. Eligible Medical Expenses are “incurred” when the medical care is provided, not when you are billed, are charged or pay for the expense. Thus, an expense that has been paid but not incurred (e.g. pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may **not** be reimbursed from an HRA Account:

- expenses incurred for qualified long term care services;
- expenses incurred *prior to the date* that you became a Participant in the HRA;
- expenses incurred *after the date* that you cease to be a Participant in the HRA; and
- expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan.

#### **Q-6. When do I cease participation in the Plan?**

You will cease being a Participant in the Plan on the earlier of:

- the date you cease to be an Eligible Retiree, Eligible Spouse or Eligible Domestic Partner for any reason;
- the date the retiree is rehired by the Employer as an active employee;
- the date you cease to be eligible for Medicare;
- your date of death;
- the effective date of any amendment terminating your eligibility under the Plan; or
- the date the Plan is terminated.

You may not obtain reimbursement of any Eligible Medical Expenses incurred after the date your eligibility ceases. (For the definition of “incurred,” see Q-5.) You have 180 days after your eligibility ceases, however, to request reimbursement of Eligible Medical Expenses you incurred before your eligibility ceased. Notwithstanding the previous sentence, in the event your eligibility ceases due to the Plan’s termination, you have 90 days after the Plan terminates to submit Eligible Medical Expense claims.

**Q-7. What happens if I do not use all of the contributions allocated to my HRA Account during the Plan Year?**

If you do not use all of the amounts credited to your HRA Account during a Plan Year, those amounts will be carried over for your use in subsequent Plan Years.

**Q-8. How do I receive reimbursement under the Plan?**

You must complete a reimbursement form and mail or fax it to the Claims Submission Agent as provided in the Plan Information Appendix, along with a copy of your insurance premium bill, an “explanation of benefits” or “EOB,” or, if no EOB is provided, a written statement from the service provider. The written statement from the service provider must contain the following: (a) the name of the patient, (b) the date service or treatment was provided, (c) a description of the service or treatment; and (d) the amount incurred. You can obtain a reimbursement form from the Third Party Administrator identified in the Plan Information Appendix. Your claim is deemed filed when it is received by the Claims Submission Agent. (Do not mail your form to the Third Party Administrator as this may result in a delay in processing.)

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received by the Claims Submission Agent.

**Q-9. What happens if my claim for benefits is denied?**

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after the Claims Submission Agent receives your claim. If the Claims Submission Agent determines that an extension of this time period is necessary due to matters beyond the control of the Plan, the Claims Submission Agent will notify you within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified and you will have at least 45 days to provide the additional information. The notice of denial will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan’s appeal procedures and the time limits applicable to such procedures; and
- a description of your right to request all documentation relevant to your claim.

If your request for reimbursement under the Plan is denied in whole or in part and you do not agree with the decision of the Claims Submission Agent, you may file a written appeal. You should file your appeal with the Plan Administrator at the address provided in the Plan Information Appendix no later than 180 days after receipt of the denial notice. You should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information that you believe would support your claim.

You will be notified in writing of the decision on appeal no later than 60 days after the Plan Administrator receives your request for appeal. The notice will contain the same type of information provided in the first notice of denial provided by the Claims Submission Agent.

Note that you cannot file suit in federal court until you have exhausted these appeals procedures.

**Q-10. What happens if I die?**

If you die without a surviving spouse or Domestic Partner who is a Participant in the Plan at the time of your death, your HRA Account is immediately forfeited upon death, but your estate or representatives may submit claims for Eligible Medical Expenses you incurred before your death. Claims must be submitted within 180 days of your death, or if earlier, within 90 days from the termination of the Plan.

If you die and your spouse or Domestic Partner is a Participant in the Plan at the time of your death, your HRA Account balance shall remain in the joint HRA Account of your spouse or Domestic Partner, and his or her benefits under the Plan will continue. He or she may submit claims for Eligible Medical Expenses you incurred before your death within 180 days of your death, or if earlier, within 90 days from the termination of the Plan

**Q-11. Are my benefits taxable?**

The Plan is intended to meet certain requirements of existing federal tax laws, under which the benefits you receive under the Plan generally are not taxable to you. However, the Employer cannot guarantee the tax treatment to any given Participant, as individual circumstances may produce different results. If there is any doubt, you should consult your own tax advisor. In addition, if you are an Eligible Domestic Partner, you will receive a statement on or before each January 31<sup>st</sup> reflecting the amounts in which you need to report as taxable income, under applicable law.

**Q-12. What happens if I receive an overpayment under the Plan or a reimbursement is made in error from my HRA Account?**

If it is later determined that you received an overpayment or a payment was made in error (e.g., you were reimbursed from your HRA Account for an expense that is later paid by another medical plan), you will be required to refund the overpayment or erroneous reimbursement to the Employer.

If you do not refund the overpayment or erroneous payment, the Employer reserves the right to offset future reimbursements equal to the overpayment or erroneous payment. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have tax implications for you.

**Q-13. How long will the Plan remain in effect?**

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason, including the right to change the classes of persons eligible for participation, to change the amount credited to HRA Accounts or to reduce or eliminate any amounts currently credited to a Participant's HRA Account.

**Q-14. How does the Plan interact with other medical plans?**

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied). You must first submit any claims for medical expenses to the other plan or plans before submitting the expenses to this Plan for reimbursement.

**Q-15. What is “continuation coverage” and how does it work?**

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), you or your Eligible Spouse may be entitled to continuation coverage under the Plan. This coverage can become available to you or your Eligible Spouse when you would otherwise lose your group health coverage.

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You or your Eligible Spouse could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

If you or an Eligible Spouse elects to continue coverage, you are entitled to the level of coverage under the Plan in effect immediately preceding the qualifying event. You may also be entitled to an increase in your HRA Account equal to the amounts contributed to the HRA Accounts of similarly situated Participants (subject to any restrictions applicable to similarly situated Participants) so long as you continue to pay the applicable premium.

In order to continue coverage, the qualified beneficiary must pay a monthly premium equal to 102% of the cost of the coverage, as determined by the Plan Administrator. The Plan Administrator will notify qualified beneficiaries of the applicable premium at the time of a qualifying event.

If you are an Eligible Spouse, you will become a qualified beneficiary if you lose your coverage under the Plan because you become divorced or legally separated from your spouse (a qualifying event). In addition, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of your coverage under the Plan, you will become a qualified beneficiary with respect to the bankruptcy. Your Eligible Spouse will also become a qualified beneficiary if bankruptcy results in the loss of his or her coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is commencement of a proceeding in bankruptcy with respect to the employer, the employer must notify the Plan Administrator of the qualifying event.

For your divorce or legal separation from your Eligible Spouse, **you must notify the Plan Administrator within 60 days after the qualifying event occurs.** You must provide this notice to:

Human Resources Department  
Southwestern University  
1001 E. University Avenue  
P.O. Box 770  
Georgetown, TX 78627

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect COBRA continuation coverage on behalf of your spouse.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is your divorce or legal separation, COBRA continuation coverage lasts for up to a total of 36 months. If your coverage is as of a result of the Employer's bankruptcy, you may continue that coverage from the date of the bankruptcy until your death, and your Eligible Spouse may continue coverage until the earlier of either: (1) your death plus an additional 36 months of coverage; or (2) your Eligible Spouse's death.

However, coverage may end earlier upon the occurrence of any of the following events:

- The date the qualified beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage;
- The date any required monthly premium is not paid when due or during the applicable grace period;
- The date, after the date of the qualified beneficiary's election to continue coverage, that he or she becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the qualified beneficiary; or
- The date the Employer ceases to provide any group health plan.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

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 to the Plan Administrator.

**Q-16. Who do I contact if I have questions about the Plan?**

If you have any questions about the Plan, you should contact the Third Party Administrator or the Plan Administrator. Contact information for the Third Party Administrator and the Plan Administrator is provided in the Plan Information Appendix.

## **PART II ERISA RIGHTS**

This Plan is an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). ERISA provides that you, as a Plan Participant, will be entitled to:

### **Receive Information about Your Plan and Benefits**

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, 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 all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may apply 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 Plan Coverage**

Continue Plan coverage for Eligible Spouses if there is a loss of coverage under the Plan as a result of a qualifying event. However, the Eligible Spouse will have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing 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 the 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 from the Plan, or from exercising your rights under ERISA.

### **Enforcement of Your Rights**

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 that 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 (e.g., if it finds your claim is frivolous).

### **Assistance with Your Questions**

If you have any questions about the 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 obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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.

**PART III  
HEALTH INSURANCE PORTABILITY AND  
ACCOUNTABILITY ACT OF 1996 (HIPAA) PRIVACY NOTICE**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT  
YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN  
GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**

**Section 1. Introduction**

The Plan is dedicated to maintaining the privacy of your health information. The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information or “Protected Health Information” (“PHI”) and to inform you about:

- the Plan’s uses and disclosures of PHI;
- your privacy rights with respect to your PHI;
- the Plan’s duties with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan’s privacy practices.

The term “Protected Health Information” or “PHI” includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic). The Plan is required by law to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices. The Plan is also required to notify you following a breach of unsecured PHI.

The Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to all PHI received or maintained by the Plan, including PHI received or maintained prior to the change. If the Plan makes a material change to its privacy practices, you will be provided with a revised Notice, or information about the material change and how to obtain the revised Notice, within 60 days of the material change.

**Please note that Southwestern University as the Plan Sponsor obtains summary PHI, enrollment and disenrollment, termination of coverage and specific appeals information from the Plan. Most records containing your PHI are created and retained by the Third Party Administrator for the Plan. In the event that the Plan Sponsor receives PHI, the Plan has been amended to require that the Plan Sponsor only use and disclose PHI received from the Plan for administrative plan purposes as permitted by federal law.**

**Section 2. Notice of PHI Uses and Disclosures**

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization.

***A. Required PHI Uses and Disclosures***

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

The Plan also will disclose PHI to the Plan Sponsor for administrative purposes permitted by law and related to treatment, payment or health care operations. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

The Plan contracts with business associates for certain services related to the Plan. PHI about you may be disclosed to the business associates so that they can perform contracted services. To protect your PHI, the business associate is required to appropriately safeguard the health information. The following categories describe the different ways in which the Plan and its business associates may use and disclose your PHI.

***B. Uses and disclosures to carry out treatment, payment and health care operations***

The Plan and its business associates will use PHI without your consent, authorization, or opportunity to agree or object, to carry out treatment, payment and health care operations.

*Treatment* is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating cardiologist the name of your treating physician so that the cardiologist may ask for your lab results from the treating physician.

*Payment* includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

*Health care operations* include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

The Plan may also use PHI to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

### ***C. Authorized uses and disclosures***

You must provide the Plan with your written authorization for the types of uses and disclosures that are not identified by this notice or permitted or required by applicable law. In addition, your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your mental health professional. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you. In addition, you must provide the Plan with your written authorization for uses and disclosures of PHI which result in the Plan receiving financial payment from a third party whose product or services is being marketed will require your authorization as well as for disclosures that constitute a sale of PHI.

Any authorization you provide to the Plan regarding the use and disclosure of your health information may be revoked at any time **in writing**. After you revoke your authorization, the Plan will no longer use or disclose your health information for the reasons described in the authorization, except for the two situations noted below:

- The Plan has taken action in reliance on your authorization before it received your written revocation; and
- You were required to give the Plan your authorization as a condition of obtaining coverage.

### ***D. Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release***

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

### ***E. Uses and disclosures for which consent, authorization or opportunity to object is not required***

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a

disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

- To a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.
- For law enforcement purposes, including to report certain types of wounds or for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. The Plan may also disclose PHI when disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- For research, subject to conditions.
- When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

### **Section 3. Rights of Individuals**

#### ***A. Right to Request Restrictions on PHI Uses and Disclosures***

You may request that the Plan restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations as required by law. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the Plan at the address provided at the end of this Notice specifying the requested method of contact or the location where you wish to be contacted.

### ***B. Right to Inspect and Copy PHI***

You have a right to inspect and obtain a copy of your PHI contained in a “designated record set,” for as long as the Plan maintains the PHI. “*Designated Record Set*” includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used by the Plan entity to make decisions about individuals.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the Plan at the address provided at the end of this Notice.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

### ***C. Right to Amend PHI***

You have the right to request the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. Requests for amendment of PHI in a designated record set should be made to the Plan at the address provided at the end of this Notice.

### ***D. Right to Receive an Accounting of PHI Disclosures***

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to you about your own PHI; (3) prior to April 14, 2004; or (4) pursuant to your authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if you are given a written statement of the reasons for the delay and the date by which the accounting will

be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting. You or your personal representative will be required to complete a form to request an accounting. Requests for an accounting should be made to the Plan at the address provided at the end of this Notice.

#### ***E. The Right to Receive a Paper Copy of This Notice Upon Request***

To obtain a paper copy of this Notice at any time contact the Plan Administrator. The Notice is also posted on the Plan Sponsor's intranet site. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

#### ***F. A Note About Personal Representatives***

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

### **Section 4. Your Right to File a Complaint With the Plan or the HHS Secretary**

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Plan Administrator. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services. The Plan will not retaliate against you for filing a complaint.

### **Section 5. Whom to Contact at the Plan for More Information**

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan's Privacy Officer, listed at the information provided below:

Elma F. Benavides  
Associate Vice President for Human Resources  
Southwestern University  
1001 E. University Avenue  
P.O. Box 770  
Georgetown, TX 78627-0770  
(512) 863-1441  
[benavide@southwestern.edu](mailto:benavide@southwestern.edu)

# PLAN INFORMATION APPENDIX

## GENERAL PLAN INFORMATION

<b>Name of Plan:</b>	Southwestern University Retiree Health Reimbursement Arrangement
<b>Effective Date:</b>	January 1, 2014
<b>Name, address, and telephone number of the Plan Sponsor:</b>	Southwestern University 1001 E. University Avenue P.O. Box 770 Georgetown, TX 78627 (512) 863-1441
<b>Name, address, and telephone number of the Plan Administrator:</b>  The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more individuals or committees.	Southwestern University 1001 E. University Avenue P.O. Box 770 Georgetown, TX 78627 (512) 863-1441
<b>Agent for Service of Legal Process:</b>	Southwestern University 1001 E. University Avenue P.O. Box 770 Georgetown, TX 78627 (512) 863-1441
<b>Sponsor's federal tax identification number:</b>	74-1233796
<b>Plan Number:</b>	504
<b>Plan Year:</b>	The 12 consecutive month period ending each December 31.
<b>Third Party Administrator:</b>	Extend Health, Inc. 10975 South Sterling View Drive Suite A-1 South Jordan, UT 84905 (866) 322-2824 <a href="http://www.ExtendHealth.com/employer">www.ExtendHealth.com/employer</a>

<b>Claims Submission Agent:</b>  All reimbursement forms, and supporting documentation, must be provided to the Claims Submission Agent. Forms should not be mailed to the Third Party Administrator.	PayFlex Systems USA, Inc. Extend Health P.O. Box 3039 Omaha, NE 68103-3039 Fax: (402) 231-4310
<b>Funding:</b>	Benefits are paid from the Employer's general assets. There is no trust or other fund from which benefits are paid.

## PLAN TERMS

1. **Eligible Domestic Partner:** Eligible Domestic Partner means an individual who has entered into a domestic partnership with an Eligible Retiree and has executed an affidavit or certification of domestic partnership form provided by the Plan Administrator and who continuously satisfies all of the requirements set forth in Section 4 below on or after the Effective Date.

2. **Eligible Retiree:** Eligible Retiree means an employee who was hired on or before July 1, 1996 and who retires from the Employer and who continuously satisfies all of the requirements set forth in Section 4 below on or after the Effective Date.

3. **Eligible Spouse:** Eligible Spouse means an Eligible Retiree's legal spouse who satisfies all of and who continuously satisfies all of the requirements set forth in Section 4 below on or after the Effective Date.

4. **Eligibility Requirements:** Each of the following requirements must be satisfied in order for an Eligible Domestic Partner, Eligible Retiree or Eligible Spouse to participate in the Plan:

- Continuously enrolled in the Health Plan from the date of Eligible Retiree's retirement until attaining age 65, or, if later, the date he or she is first otherwise eligible to participate in the Plan;
- Eligible for Medicare or a similar government-sponsored retiree health plan;
- Is enrolled in Medicare Part B or a similar government-sponsored retiree health plan;
- Is enrolled in a Medicare Supplemental Policy, including Medicare Part D; and
- Completes all enrollment forms or procedures required by the Plan Administrator.

4. **Account Structure:**

Only one HRA Account will be established for married Participants and Participants in Domestic Partnerships and all contributions for such Participants will be credited to such HRA Account.

5. **Contribution Amounts:**

The amount of contributions will be determined by the Employer in its sole discretion. The Employer reserves the right to amend the contribution amount in its sole discretion at any time. It is anticipated that the following annual amount will be contributed on behalf of Participants who are Eligible Retirees, Eligible Spouses or Eligible Domestic Partners:

Beginning January 1, 2014 through December 31, 2018, it is anticipated that the contribution amount shall equal the average Medicare Supplemental Plan L and Medicare Part D premiums in Travis and Williamson Counties (determined by age and gender, in single-year increments). Beginning on January 1, 2019, it is anticipated that the contribution amount shall be capped at the 2018 average premiums. The Employer may change the contribution amount at any time in its sole discretion.

6. **Timing of Contributions:** Contributions will be made to the HRA Accounts on or about the first day of each Plan Year.