

Summary of Coverage

Employer: Rider University

ASA: 884014

SOC: 1C

Issue Date: January 25, 2008

Original Effective Date: January 1, 2007

The benefits shown in this Summary of Coverage are available for you and your eligible dependents.

Eligibility

Employees

You are in an Eligible Class if you are a regular full-time employee working 30 hours or more per week, or you are an eligible member of the AAUP as defined by your AAUP contract guidelines, and you elect the Aetna Choice POS II Safety Net Plan.

Your Eligibility Date is the first day of the calendar month coinciding with or next following the date you complete a probationary period of 30 days of continuous service for your Employer, but not before the later of the Effective Date of this Plan and the date you enter the Eligible Class.

To be eligible for retiree benefits you must have 10 years of service as a full-time employee with your Employer.

You can remain in an Eligible Class as a retired employee if under age 65 and when you terminate active employee status you are enrolled in one of your Employer's health plans and you have satisfied the criteria for retirement. You must have reached age 60 and completed 10 years of service with your Employer. You may continue your Health Expense Coverage and any coverage you have for your dependents.

If you retired before the Effective Date of this Plan, you are also in an Eligible Class. You must follow the Enrollment Procedure.

Dependents

You may cover your:

- wife or husband; and
- unmarried children who are under 23 years of age, and dependent on you for support and maintenance.

If you have completed and signed a "Declaration of Domestic Partnership" and the Declaration is acceptable to your Employer, you may also cover as your dependent the person who is the "domestic partner" named in your Declaration.

Your children include:

- Your biological children.
- Your adopted children.
- Your stepchildren.
- Any other child you support who lives with you in a parent-child relationship.

Aetna Choice POS II - Safety Net Plan

Please refer to the **General Information About Your Coverage** section of your Booklet for special information applicable to Handicapped Dependent Children.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

Enrollment Procedure

Initial Enrollment

To become covered under this Plan, you must request enrollment during the Initial Enrollment Period for yourself and any eligible dependents you wish to cover. The Initial Enrollment Period starts on your Eligibility Date and ends 31 days later.

You will be required to enroll in a manner determined by Aetna and your Employer. This will allow your Employer to deduct your contributions from your pay. Be sure to enroll before the end of the Initial Enrollment Period. Otherwise, you may be considered a **Late Enrollee**.

Your contributions toward the cost of this coverage will be deducted from your pay and are subject to change. The rate of any required contributions will be determined by your Employer. See your Employer for details. If you are eligible for any coverage as a retired employee, your Employer will advise you concerning the method and amount of any required contributions.

Late Enrollment

If you do not sign and return your enrollment form during the Initial Enrollment Period, you and your eligible dependents may be considered **Late Enrollees** and coverage may be deferred until the next late entrant enrollment period. If at the time of your initial enrollment, you elect coverage for yourself only and later request coverage for your eligible dependents, they may be considered **Late Enrollees**.

You must sign and return your enrollment form before the end of the next late entrant enrollment period.

However, you and your eligible dependents may not be considered **Late Enrollees** under the circumstances described in the "Special Enrollment Periods" section below.

Special Enrollment Periods

A person, including yourself, will not be considered to be a **Late Enrollee** if all of the following are met:

- You did not elect Health Expense Coverage for yourself or any eligible dependent during the Initial Enrollment Period (or during a subsequent late enrollment period) because at that time:
 - i. the person was covered under another group health plan or other health insurance coverage; and
 - ii. you stated, in writing, at the time you refused coverage that the reason for the refusal was because the person had such coverage, but such written statement is required only if your Employer requires the statement and gives you notice of the requirement; and

the person loses such coverage because:

- i. it was provided under a COBRA continuation provision, and coverage under that provision was exhausted; or
- ii. it was not provided under a COBRA continuation provision, and either the coverage was terminated as a result of loss of eligibility for the coverage, including loss of eligibility as a result of:
 - legal separation or divorce;
 - death;
 - termination of employment;
 - reduction in the number of hours of employment;
 - the employer's decision to stop offering the group health plan to the Eligible Class to which the employee belongs;
 - cessation of a dependent's status as an eligible dependent as such is defined under this Plan;
 - the operation of another Plan's lifetime maximum on all benefits, if applicable; or

iii. employer contributions toward the coverage were terminated.

- You elect coverage within 31 days of the date the person loses coverage for one of the above reasons. In addition, you and any eligible dependents will not be considered to be **Late Enrollees** if your Employer offers multiple health benefit plans and you elect a different plan during the open enrollment period.

Also, the following persons will not be considered to be **Late Enrollees** given any of the following circumstances:

- You, if you are eligible, but not enrolled, and your newly acquired dependents through marriage, birth, adoption, or placement for adoption. However, you must request enrollment for your newly acquired dependent(s) and yourself, if you are not already enrolled, within 31 days of the marriage, birth, adoption, or placement for adoption.
- Your spouse from whom you are separated or divorced, or child who would meet the definition of a dependent, if you are subject to a court order requiring you to provide health expense coverage for such spouse or child. However, you must request enrollment within 31 days of the court order.

Coverage will be effective:

- i. in the case of marriage, on the date the completed request for enrollment is received;
- ii. in the case of a newborn, on the date of birth;
- iii. in the case of adoption, on the date of the child's adoption or placement for adoption;
- iv. in the case of court ordered coverage of a spouse or child, on the date of the court order;
- v. in the case of loss of coverage under COBRA continuation, on the date COBRA continuation ended; and
- vi. in the case of loss of coverage for other reasons, the date on which the applicable event occurred.

Effective Date of Coverage

Employees

Your coverage will take effect on your Eligibility Date provided you have completed your election form.

If you are considered a **Late Enrollee**, coverage will take effect on the first day of the second calendar month following the end of the late entrant enrollment period during which you elect coverage.

Dependents

Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage.

You should report any newly acquired dependents. This may affect your contributions. Coverage will take effect as described in the section entitled, "Special Enrollment Periods".

If any dependent is considered a **Late Enrollee**, coverage will take effect on the first day of the second calendar month following the end of the late entrant enrollment period during which you elect coverage for such dependent.

Note: This Plan will pay a benefit for Covered Medical Expenses incurred by a newborn child during the first 31 days of life, whether or not the child is or becomes enrolled under the Plan.

If the child does not become enrolled under the Plan, coverage will terminate at the end of such 31 day period. Any Extension of Benefits provision described under the Health Expense Benefits After Termination subsection in your Booklet will apply. The Continuation of Coverage under Federal Law provision will not apply.

Special Rules Which Apply to an Adopted Child

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date your coverage becomes effective; and
- you make written request for coverage for the child within 31 days of the date the child is placed with you for adoption.

Coverage for the child will become effective on the date the child is placed with you for adoption. If request is not made within such 31 days, coverage for the child will be subject to all of the terms of this Plan.

(The preceding paragraph may not be applicable to your Plan. Please check with Human Resources.)

Special Rules Which Apply to a Child Who Must Be Covered Due to a Qualified Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order issued on or after the date your coverage becomes effective. You must make written request for such coverage. Coverage for the child will become effective on the date specified by your Employer.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

(The preceding paragraph may not be applicable to your Plan. Please check with Human Resources.)

Retired Employees

In lieu of corresponding rules which apply to employees:

- If any Health Expense Benefits are payable based on a "period of disability", the rule which applies to determine when a dependent's period of disability ends will also apply to you.
- The rule which applies to a dependent to determine if total disability exists when Health Expense Coverage terminates will also apply to you.

Health Expense Coverage

Employees and Dependents

Your Booklet spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet for a complete description of the benefits payable.

Prescription Drug Expense Coverage

Payment Percentage

100% as to:

Preferred (In-Network) Retail Pharmacy	Copay per Prescription or Refill		
	Supply of up to 30 days	Supply of 30 – 60 days	Supply of 60 – 90 days
Generic Drugs	\$ 10	\$ 20	\$ 30
Brand Name Drugs On Medication Formulary	\$ 15	\$ 30	\$ 45
Not on Medication Formulary	\$ 30	\$ 60	\$ 90

Preferred (In-Network) MOD Pharmacy	Copay per Prescription or Refill	
	Mail Order Drug Supply of over 30 days*	
Generic Drugs	\$ 20	
Brand Name Drugs On Medication Formulary	\$ 30	
Not on Medication Formulary	\$ 60	

* but no more than a 90 day maximum supply.

70% as to:

Drugs and Medicines dispensed by a Non-Preferred (Out-of-Network) Pharmacy

Note: Non-Preferred (Out-of-Network) Pharmacy expenses are payable under and subject to the terms of the Medical Expense Coverage section of this Plan, including the Calendar Year Deductible.

Refer to your Booklet for additional limitations.

Special Comprehensive Medical Expense Coverage

Note: You may select a Primary Care Physician to assist you in managing your health care when you use Preferred (In-Network) Care Providers. While you are not required to do so, you are encouraged to select a Primary Care Physician so you have the opportunity to work with one physician who can coordinate all of your health care needs. Your Primary Care Physician (if selected) coordinates your medical care, except care for the treatment of alcoholism, drug abuse, or a mental disorder. The Behavioral Health Care Coordinator (BHCC), if requested, coordinates your medical care for the treatment of alcoholism, drug abuse, and a mental disorder.

For the preferred (in-network) level of benefits, you are encouraged to contact the BHCC, at the number shown on your ID card, before you receive any care for the effective treatment of alcoholism, drug abuse, or a mental disorder for a recommendation of treatment which is approved by the BHCC.

Certification Requirements

You are encouraged to obtain certification for certain types of Non-Preferred (Out-of-Network) Care to ensure that the care will be considered a Covered Medical Expense. Read the Special Comprehensive Medical Expense Benefits section of the Booklet for details of the types of care affected and how to get certification.

Certification for Hospital Admissions, Residential Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Skilled Nursing Care is encouraged, however there is no penalty for failure to obtain certification.

For Preferred (In-Network) Care, the provider will obtain certification for you.

Deductible and Copay Amounts

Calendar Year Deductible \$ 500

This Calendar Year Deductible applies to all expenses incurred for Non-Preferred (Out-of-Network) Care and for care for dependents who permanently reside outside the Service Area covered under this Plan, except:

Emergency Use of the Emergency Room
Ambulance Expenses

Family Deductible Limit \$ 1,500

Emergency Room Deductible \$ 35 per visit

This Emergency Room Deductible applies to Hospital Expenses incurred for emergency care provided by a Non-Preferred (Out-of-Network) Care Provider and for care for dependents who permanently reside outside the Service Area covered under this Plan. This amount is waived if a person becomes confined in a hospital.

Emergency Room Copay \$ 35 per visit

This Emergency Room Copay applies to Hospital Expenses incurred for emergency care provided by a Preferred (In-Network) Care Provider. This amount is waived if the person becomes confined in a hospital.

The Benefits Payable

After any applicable deductible or copay amount, the Health Expense Benefits paid under this Plan in a calendar year are paid at the Payment Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Booklet.

If any expense is covered under one type of Covered Medical expense, it cannot be covered under any other type.

Payment Limits (Coinsurance Limits) for Preferred (In-Network) Care and Non-Preferred (Out-of-Network) Care

These limits apply to Covered Medical Expenses except:

Expenses applied against any deductible or copay amount.

Payment Limits which Apply to Expenses for a Person

When a person's Covered Medical Expenses incurred for Preferred (In-Network) Care, for which no benefits are paid because of the Payment Percentage, reach \$ 1,500 in a calendar year, benefits will be payable at 100% for all his or her Covered Medical Expenses to which this limit applies and which are incurred for Preferred (In-Network) Care in the rest of that calendar year.

When a person's Covered Medical Expenses incurred for Non-Preferred (Out-of-Network) Care, for which no benefits are paid because of the Payment Percentage, reach \$ 3,000 in a calendar year, benefits will be payable at 100% for all his or her Covered Medical Expenses to which this limit applies and which are incurred for Non-Preferred (Out-of-Network) Care in the rest of that calendar year.

Payment Limits which Apply to Expenses for a Family

When a family's Covered Medical Expenses incurred for Preferred (In-Network) Care, for which no benefits are paid because of the Payment Percentage, reach \$ 4,500 in a calendar year, benefits will be payable at 100% for all their Covered Medical Expenses to which this limit applies and which are incurred for Preferred (In-Network) Care in the rest of that calendar year.

When a family's Covered Medical Expenses incurred for Non-Preferred (Out-of-Network) Care, for which no benefits are paid because of the Payment Percentage, reach \$ 9,000 in a calendar year, benefits will be payable at 100% for all their Covered Medical Expenses to which this limit applies and which are incurred for Non-Preferred (Out-of-Network) Care in the rest of that calendar year.

Payment Percentage

The Payment Percentage applies after any deductible or copay amounts.

National Medical Excellence

Travel and Lodging Expenses 100%

	Preferred (In-Network) Care	Non-Preferred (Out-of Network) Care
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Hospital Expenses

Emergency Room
Treatment

Emergency Care	90% after a \$ 35 copay	90% after a \$ 35 deductible
Other Hospital Expenses	100% Inpatient 90% Outpatient	70% Inpatient 70% Outpatient

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, Aetna will use the following allocations of these charges for the purposes of the group contract:

Room and board charges:	40%
Other charges:	60%

This allocation may be changed at any time if Aetna finds that such action is warranted by reason of a change in factors used in the allocation.

	Preferred (In-Network) Care	Non-Preferred (Out-of Network) Care
<i>Physician Fees</i>		
Office Care	100% after a \$ 15 copay	70%
Routine Physical Exam Expenses	100% after a \$ 15 copay	70%
Routine Eye Exam Expenses	100% after a \$ 15 copay	70%
Routine Hearing Exam Expenses	100% after a \$ 15 copay	70%
Other Physician Services (For example, surgeons' services)	100% Inpatient 90% Outpatient	70% Inpatient 70% Outpatient
Covered Medical Expenses incurred in connection with routine screening for cancer: *		
Mammogram;	100% **	70%
Pap smear;	100% after a \$ 15 copay	70%
Prostate specific antigen (PSA) test;	100% after a \$ 15 copay	70%
* Refer to your Booklet for specific limitations.		
** Copay waived when office visit charge is not made.		
<i>Other Covered Medical Expenses</i>		
Convalescent Facility Expenses	90%	70%
Home Health Care Expenses	90%	70%
Skilled Nursing Care Expenses	90%	70%
Hospice Care Expenses		
Inpatient Care	100%	100%
Outpatient Care	100%	100%
Short-Term Rehabilitation Expenses	100% after a \$ 15 copay	70%

Ambulance Expenses	90%	90%
Diagnostic X-ray and Laboratory Expenses	90%	70%
Allergy Testing	100% after a \$ 15 copay	70%
Allergy serum, allergy injections and injectable drugs	100% after a \$15 copay *	70%

* Copay waived when office visit charge is not made.

Durable Medical Equipment	90%	70%
Healthy Outlook Program	90%	70%
All Other Covered Medical Expenses for which a Payment Percentage is not otherwise shown	90%	70%

Benefit Maximums

(Read the coverage section in your Booklet for a complete description of the benefits available. All maximums included in this Plan are combined maximums between Preferred (In-Network) Care and Non-Preferred (Out-of-Network) Care, where applicable, unless specifically stated otherwise.)

Convalescent Days	90 per calendar year
Home Health Care Maximum Visits	200 per calendar year
National Medical Excellence	
Lodging Expenses Maximum	\$ 50
Travel and Lodging Maximum	\$ 10,000
Private Room Limit	The institution's semiprivate rate.

Coverage for Dependents Who Permanently Reside Outside the Service Area

Covered Medical Expenses for dependents who permanently reside outside the Service Area covered under this Plan include the types of expenses listed under Non-Preferred (Out-of-Network) Care. Benefits will be paid at 70%, except that Outpatient Treatment of Alcoholism, Drug Abuse and Mental Disorders will be paid at 50%.

Payment Percentage and Maximums

	Preferred (In-Network) Care	Non-Preferred (Out-of Network) Care
<i>Alcoholism, Drug Abuse, and Mental Disorders Expenses</i>		
Inpatient Treatment	100%	70% after deductible
Calendar Year Maximum Days		75
Outpatient Treatment	100% after a \$ 15 copay	50% after deductible

Pregnancy Coverage

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for a disease.

In the event of an inpatient confinement, the following federal guidelines are applicable, however your plan will cover additional benefits when medically necessary:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending physician, a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider.
- Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Certification for any day of confinement in excess of such limits is encouraged. You, your physician, or other health care provider may obtain such certification by calling the number shown on your ID Card.

Normally, the expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the coverage ceases, they will be considered for benefits only if satisfactory evidence is furnished to Aetna that the person has been totally disabled since her coverage terminated.

Prior Plans: Any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under this Plan.

Sterilization Coverage

Health Expense Coverage: Benefits are payable for charges made in connection with any procedure performed for sterilization of a person, including voluntary sterilization, on the same basis as for a disease.

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, e.g. as a result of plan design changes which may be effective prior to revision of the plan booklets, coverage will be adjusted as provided elsewhere in the plan document on file with your Employer.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under your plan of health benefits. Requests for coverage other than that to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

**KEEP THIS SUMMARY OF COVERAGE
WITH YOUR BOOKLET**

Additional Information Provided by Rider University

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet. Your Plan Administrator has determined that this information together with the information contained in your booklet is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Employer Identification Number:

21-0650678

Plan Number:

501

Type of Plan:

Welfare

Type of Administration:

Administrative Services Contract with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:

Vice President for Finance and Treasurer
Rider University
2083 Lawrenceville Road
Lawrenceville, NJ 08648

Agent for Service of Legal Process:

Vice President for Finance and Treasurer
Rider University
2083 Lawrenceville Road
Lawrenceville, NJ 08648

End of Plan Year:

December 31

Source of Contributions:

Employer/Employee

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by the Vice President for Finance and Treasurer, except where such action is subject to the provisions of a collective bargaining agreement.

Claim Procedures

The claim procedures described below apply to health claims filed on or after November 1, 2004. Claims filed prior to said date(s) will be subject to the claim procedures in effect prior to the applicable date.

Your booklet contains information on reporting claims. Claim forms may be obtained at your place of employment. These forms tell you how and when to file a claim.

Note: If applicable state law requires the Plan to take action on a claim or appeal in a shorter timeframe, the shorter period will apply.

Filing Health Claims under the Plan

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company. The notice will explain the reason for the denial and the review procedures.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

Urgent Care Claims

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your physician determines that it is an urgent care claim, you will be notified of the decision not later than 72 hours after the claim is received.

"A claim involving urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30 day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the Plan intends to terminate or reduce benefits for the previously authorized course of treatment so that you will have an opportunity to appeal the decision and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Filing an Appeal of an Adverse Benefit Determination

Health Claims – Standard Appeals

You will have 180 days following receipt of an adverse benefit decision to appeal the decision to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Member Services. Aetna's Member Services telephone number is on your Identification Card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision, you may file a second level appeal within 60 days of receipt of the level one appeal decision. The appeal will be handled in the same timeframes as the first level appeal and a notice will be sent to you explaining the decision.

Health Claims – Voluntary Appeals

You may file a voluntary appeal to The University of any final standard appeal determination. Subject to verification procedures that the Plan may establish, your authorized representative may act on your behalf in filing and pursuing this appeal. All of the levels of standard appeal described above must be completed before you can file a voluntary appeal. The appeal must be filed for review within 60 days after you receive the final denial notice under the standard appeal processes, described above.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action. If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

If you choose to appeal to The University following an adverse determination at the final level of standard appeals, you must do so in writing, and you should send the following information:

- The specific reason(s) for the appeal;
- Copies of all past correspondence with your Health Plan (including any EOBs); and
- Any applicable information that you have not yet sent to your Health Plan.

If you file a voluntary appeal, you will be deemed to authorize The University to obtain information from your Health Plan relevant to your claim.

Mail your written appeal directly to:

Vice President for Finance and Treasurer
Rider University
2083 Lawrenceville Road
Lawrenceville, NJ 08648

The University will review your appeal. The University reviewer will evaluate your claim within 60 days after you file your appeal and make a decision. If the reviewer needs more time, the reviewer may take an additional 60-day period. The reviewer will notify you in advance of this extension. The University reviewer will follow relevant internal rules maintained by the applicable Health Plan to the extent they do not conflict with its own internal guidelines.

The University reviewer will notify you of the final decision on your appeal electronically or in writing. The written notice will give you the reason for the decision and what Plan provisions apply.

All decisions by The University with respect to your claim shall be final and binding.

You may pursue legal action regardless of whether or not you choose to file a voluntary appeal to the University if you have exhausted the applicable Level one and Level two processes of the Appeal Procedure as described in the Exhaustion of Process section below.

Exhaustion of Process

You must exhaust the applicable Level one and Level two processes of the Appeal Procedure before you:
contact the Department of Insurance to request an investigation of a complaint or Appeal; or
file a complaint or Appeal with the Department of Insurance; or
establish any:
litigation; or
arbitration; or
administrative proceeding;
regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

ERISA Rights

As a participant in the group benefit plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall 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) that is 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, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

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

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

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 your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain 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 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 up to \$ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a 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, 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.

Additional Information

Retrospective Record Review

The purpose of retrospective review is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage and payment of healthcare services. Aetna’s effort to manage the services provided to members includes the retrospective review of claims submitted for payment, and of medical records submitted for potential quality and utilization concerns.

Concurrent Review and Discharge Planning

The following items apply if certification applies to any confinement, services, supplies, procedures, or treatments:

Concurrent Review

The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.

Discharge Planning

Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by the member upon discharge from an inpatient stay.

Provider Networks

If plan benefits differ depending on whether care is given by, or accessed through, a network provider, you may obtain, without charge, a listing of network providers from your Plan Administrator, or by calling the toll - free Member Services number on your ID Card. A current list of providers in the Aetna network is available through DocFind[®], at www.aetna.com.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice regarding Women's Health and Cancer Rights Act

Under this health plan, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

- (1) reconstruction of the breast on which a mastectomy has been performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (3) prostheses; and
- (4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.