USA.603167236.4/SFY

The Saint Louis University
Welfare Benefit Plan

Summary Plan Descript�耀fePlŐ.m��ଏㅙ楰༐�䂀�ʑ写褀̀

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ELIGIBILITY
Eligible Employees
You are eligible to participate in the Plan if you are classified by the University as:
 a regular full-time employee; or
 a member of the medical faculty with a joint appointment with the University and the
Veteran’s Administration who receives an annual salary of at least $5,000 from the
University;
 a tenured faculty member participating in approved phased retirement.
For eligibility purposes, a full-time employee is an employee who is scheduled to work at least 32
hours per week on a regular and continuous basis. However, as described in the “Counting Hours
of Service for Medical Coverage” section, full-time employee status for participation in medical
coverage is based on averaging at least 30 hours of service per week over a specified period.

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Counting Hours of Service for Medical Coverage
A new employee, who is reasonably expected at the time of hire to average at least 30 hours of
service per week, will be offered medical coverage under the Plan (subject to satisfaction of any
other eligibility requirements) on the presumption that he or she will be scheduled to work at least
32 hours per week. Following the employee’s completion of 12 full months of employment, his or
her continuing eligibility for medical coverage for a subsequent plan year (the “Stability Period”) will
be based on the employee’s average number of hours of service for the specified 12-month period
(the “Measurement Period”) prior to the start of the Stability Period.
Employees who average at least 130 hours of service per month (i.e., the monthly equivalent of 30
hours of service per week) during the Measurement Period will be eligible for medical coverage for
the following Stability Period; provided they are not members of the excluded class of ineligible
individuals. The Plan may use the weekly rule under the monthly measurement method (discussed
below) will have to divide the year into four- and five-week periods—which act as proxies for
months—and employees averaging at least 30 hours per week during those periods will be treated as
full-time employees
The term “hour of service” refers to each hour for which you are paid, or entitled to payment, for
the performance of duties for the University; and each hour for which you are paid, or entitled to
payment, by the University for a period of time during which no duties are performed due to
vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of
absence. However, an hour of service does not include any hours after you terminate employment,
or hours paid solely to comply with a workers’ compensation law. With respect to short- or long-term disability leave, an hour of service is credited only for periods during which you retain
employee status and receive disability benefits directly or indirectly funded by the University.
If you are an hourly employee, your actual hours of service will be calculated based on the records of
hours worked and non-worked hours for which payment is made or due (e.g., vacation, holiday,
illness, incapacity, etc.). For salaried employees, the University will calculate hours of service using
one of the following three methods: (1) actual counting of hours of service; (2) using a days-worked
equivalency (i.e., eight hours of service for each day for which the employee is entitled to pay for
worked or non-worked time); or (3) using a weeks-worked equivalency (i.e., 40 hours of service per
week for each week for which the employee is entitled to pay for worked or non-worked time).
In the case of adjunct faculty members, the University credits 2.25 hours of service for each hour of
teaching or classroom time (i.e., an additional 1.25 hours is credited for activities such as class
preparation and grading). In addition, the University credits one hour of service for each additional
hour you spend on other non-classroom duties (e.g., required office hours or required attendance at
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If required by a qualified medical child support order (“QMCSO”), you and/or an eligible
dependent child will be enrolled for medical, dental and/or vision coverage(s) in accordance with
the terms of the order. Upon written request to the Plan Administrator, you may obtain, without
charge, a copy of the Plan’s procedures governing QMCSO determinations.
ENROLLMENT
Initial Enrollment Period
If you are eligible to participate in any elective benefit available under a Plan as an employee, the
Plan Administrator will send you information on how to enroll. You will have 31 days (or such
other period specified in the applicable Benefit Booklet) after the date you first become eligible to
enroll in any elective benefits in accordance with the procedures established by the University. If
you fail to enroll within your 31-day initial enrollment period, you will be treated as having declined
coverage for yourself and your dependents under the elective benefits for the remainder of the Plan
Year. You may not enroll or otherwise change any coverage elections until the next annual Open
Enrollment period, unless you become entitled to a special enrollment right or experience a
qualifying event permitting a mid-year change.
Generally, non-elective benefits that do not require any employee contributions automatically are
made available to you under the Plan upon your satisfaction of the applicable eligibility requirements
and no enrollment elections are required. Long-term disability coverage is not considered a fully
non-elective benefit since certain employees are required to contribute towards their coverage. The
University automatically enrolls eligible employees in long-term disability coverage but such
employees may make an election to disenroll in coverage at any time.
If you are an eligible retiree, the Plan Administrator will send you information on how to enroll (or
continue participation) in medical coverage under the Plan. You will have 60 days after you retire
from the University to enroll in medical coverage as a retiree in accordance with the procedures
established by the University. You must reenroll in medical coverage as a retiree even if ven icीMelीхΐ怄耀 iys 6怀㎑馃elsPo 退儀f yf madea i mee`�怀 @рm倹؀䜀 遠Ҁcti
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in effect for the Plan Year, subject to any permissible mid-year election or annual enrollment
changes and restrictions in the applicable Benefit Booklet. Unless otherwise provided in a Benefit
Booklet, your other Plan benefits continue during the approved leave of absence for up to six

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you qualify as an eligible employee. If you are rehired but you are not eligible to participate in the
Plan in your new position, your retiree medical coverage under the Plan will remain in effect unless
you subsequently become eligible for medical coverage under the Plan as an active employee.
CHANGING YOUR COVERAGE MID-YEAR
Change in Status Events
Your enrollment elections and coverage levels for any benefit(s) as an employee generally are
irrevocable and remain in place for the entire Plan Year. However, you may revoke or change your
elections within a Plan Year if you experience any of the following change in status events:
 An event that changes your legal marital status, including marriage, death of spouse, divorce,
legal separation, or annulment.
 An event that changes the number of your dependents, including birth, adoption, placement
for adoption, or death.
 Changes in your, your spouse’s or your dependent’s place of residence that result in a gain or
loss of eligibility for coverage.
 A change in your, your spouse’s, or your dependent’s employment status, including a
termination or commencement of employment, a strike or lockout, a commencement or
return from an unpaid leave of absence, or a change in worksite that results in a gain or loss
of eligibility for coverage.
 An event that causes your dependent to satisfy or cease to satisfy the requirements for
dependent coverage as provided in the Plan.
 An order by a court or state child support agency resulting from a divorce, legal separation,
annulment, or change in custody, requiring you to provide health coverage for your
child(ren).
Other Coverage Changes
You also may make an election change with respect to a Benefit Component in response to certain
plan or coverage changes. However, these rules do not apply to health flexible spending accounts.
 Change Under Other Employer Plan. You may make a change in your benefit election that
is on account of and corresponds with a change made under another employer plan
(including a plan of your spouse’s or dependent’s employer).
 Significant Cost Change. If the employee contribution for a benefit option significantly
increases or significantly decreases during the Plan Year, you can make a corresponding
change in election to enroll in the benefit with the decreased cost, or, in the case of an
increase in cost, revoke your election for that coverage and enroll in another benefit option
providing similar coverage or drop coverage if no other benefit option providing similar
coverage is available.

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medical, dental or vision coverage terminates on the last day of the month in which eligibility
ends;
 The date you fail to timely pay the required premiums or contributions, if any, toward the
cost of the applicable Plan coverage;
 The date you elect to terminate such coverage, provided such an election is permissible
under the Plan (or applicable Benefit Component);


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Among other things, this means that you generally will be responsible for payment of the entire cost
of coverage and an administrative fee during the period that benefits are continued under COBRA.
Your period of coverage during FMLA leave will not be counted toward the maximum number of
months of coverage you are permitted under COBRA.
Failure to Pay

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If an employee drops coverage for a spouse in anticipation of a divorce, the spouse is still entitled to
36 months of COBRA coverage but measured from the date of the divorce and not from the date of
the loss of coverage.
Your dependent children will become qualified beneficiaries if they lose group health coverage under
a Plan because of the following COBRA qualifying events:
 The parent-employee diesehe d냱ᖖ需fntπ

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the child is the same as the maximum period that applies to other members of the family. It is not
measured from the date of the birth, adoption, or placement for adoption. You must notify the
COBRA Administrator within 30 days of the birth.
Maximum COBRA Continuation Period
When the qualifying event is the death of the employee, the employee’s becoming entitled to

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If you or your enrolled dependents are covered by any other health plan (for example, if your child
also has medical coverage through your spouse’s plan), benefits from the Plan and the other plan

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benefits under this Plan (including any Component Benefit) must be made within one year after the
date the expense was incurred that gives rise to the claim. It is the responsibility of the covered
employee or dependent (or his or her designee) to make sure this requirement is met.
Limitations Period for Filing Suit

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procedures as soon as possible but not later than 5 days after the claim was received. If an
extension is needed because you have not submitted all the necessary information, the notice
of extension will specifically describe the additional information that you must provide. You
will be afforded at least 45 days from your receipt of the notice to provide the specified
information. The extended claim determination period will be tolled on the date that the

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rights.
If you wish to have an internal review of the denied claim, you must notify the Appeals
Administrator in writing within 180 days of the date you receive notice of the denial (however, if the

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 Prior to issuing an adverse benefit determination on a medical claim based on a new or
additional rationale, the Plan shall provide you or your representative, free of charge, with the
rationale. Such rationale will be provided as soon as possible and sufficiently in advance to
provide you or your representative a reasonable opportunity to respond prior to the due date
for notice of the final decision on appeal.
 Additionally, no decisions involving hiring, compensation, termination, promotion, or related
matters regarding any individual (e.g., a claims adjudicator or medical expert) may be based on
the likelihood that the individual will support the benefits denial.
Timing of Decision on Appeal
 Post-Service Claim. The Appeals Administrator will decide the appeal and notify you of its
decision within a reasonable period but not later than 60 days (30 days of two levels of
appeals is required) after receipt of your appeal.
 Pre-Service Claim. The Appeals Administrator will decide the appeal and notify you of its
decision within a reasonable time appropriate to the medical circmideycl�㤆tsxrcifidea of youtpoutc�䠀ni wC遠Ԡasi w←㦙だӀfo lvdmCld

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 any specific internal rule, guideline, protocol, or similar criterion which was relied upon
in denying the claim or a statement that it will be provided free of charge upon request;
 if the denial is based on a medical necessity or experimental treatment or a similar
exclusion or limit, either an explanation of the scientific or clinical judgment for the
determination, applying the terms of the Plan to your medical circumstances, or a
statement that such explanation will be provided free of charge upon request.
In the case of an adverse determination of a medical claim on appeal, the notice also will include:
 sufficient information to identify the claim involved, including the date of service, the
health care provider, the claim amount (if applicable) and a statement describing the
availability, upon request, of the diagnosis and treatment codes (along with the
corresponding meaning of such codes);
 a description of the Plan’s standard, if any, used in denying the claim on review;
 a description of available internal appeals and external review procedures;
 the availability of (and contact information for) any applicable ombudsman established
under law to assist individuals with the external review procedures; and
 in the case of a final internal adverse benefit determination, a discussion of the decision
External Review (Medical Only)
After exhaustion of all appeal rights stated above, you may be eligible to request that the claim be
reviewed under the Plan’s external review process. An external review is available for any adverse
benefit determination on medical claims involving: (1) medical judgment (excluding those that
involve only contractual or legal interpretation without any use of medical judgment) as determined
by the external reviewer or (2) a rescission of coverage (whether or not the rescission has any effect
on any particular benefit at the time). However, an external review is not available with respect to
any denial, reduction, termination, or a failure to provide payment for a benefit relating to your
failure to meet the Plan’s eligibility requirements.
To assert this right to an independent external review, you (or your authorized representative) must
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with a health care professional with appropriate training and experience in the field of medicine
involved in the medical judgment. The health care professional who is consulted will be an
individual who is neither an individual who as consulted in connection with the adverse benefit
determination that is the subject of the appeal, nor a subordinate of that individual. Upon request,

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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 copies of all plan documents and other plan information upon written request to the
Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
 Receive a summary of the Plan’s annual financial report. The Plan Administrator is required
by law to furnish each participant with a copy of this summary annual report.
 Continue health care coverage for yourself, spouse or dependents if there is a loss of such
coverage under the Plan as a result of a COBRA qualifying event. You or your dependents
must pay for such coverage. Review this summary plan description and the documents
governing the Plan on the rules governing your COBRA continuation coverage rights.
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 or yourd “fiduce discrimud��ՠofpone ucwhiciantloe袈袈袈袈堀lh
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Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington,
D.C. 20210.
You may also obtain certain publications about your rights and responsibilities under ERISA by
calling the publications hotline of the Employee Benefits Security Administration.
ERISA PLAN INFORMATION
A Benefit Booklet may include information that appears to conflict with the ERISA information
listed below for the Plan. In most cases, the information in the Benefit Booklet pertains to that
respective component of the Plan and not to the Plan. In the event of a conflict between the
ERISA information in a Benefit Booklet and the information listed below, this section governs.
Plan Name and Number
The Saint Louis University Welfare Benefit Plan (Plan Number 518)
Type of Plan
The Plan is an employee welfare benefit plan, within the meaning of ERISA Section 3(1), providing
medical, prescription drug, dental, vision, long-term disability, basic and voluntary life and accidental
death and dismemberment, business travel accident and voluntary accident benefits.
Plan Year
January 1 through December 31.
Plan Sponsor and Employer Identification Number
Saint Louis University
3545 Lindell Blvd.
Wool Center
St. Louis, MO 63103
EIN: 43-0654872
Plan Administrator
Saint Louis University
3545 Lindell Blvd.
Wool Center
St. Louis, MO 63103
(314) 977-2595
As the Plan Administrator, the University has full discretionary authority to control and manage the
overall operation and administration of the Plan, to construe and interpret the Plan, construe any
ambiguous provisions of the Plan, make benefits decisions with respect to the self-insured benefits
(except to the extent such authority has been delegated to a third-party), correct any defect, supply
any omission and reconcile any inconsistency in such manner and to such extent as the Plan

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Administrator in its sole discretion may determine. The Plan Administrator has engaged a third-party to administer claims for one or more of the self-funded benefits (e.g., medical plan). From
time to time, the Plan Administrator may also delegate certain day-to-day administrative functions
to the Human Resources Department.
With respect to benefits offered through an insurer, such benefits are fully operated, administered
and financed by the insurer designated in the applicable Benefit Booklet and such insurer has
complete discretionary authority to interpret its Benefit Booklet and group policy and to determine
the proper payment of any claim.
Consult the applicable Benefit Booklets for the name and contact information of the third-party
claims administrator or insurer.
Funding
With the exception of medical and prescription drug coverages, the benefits provided under the Plan
are fully insured pursuant to one or more group insurance policies. The insurance companies, not
the University, are responsible for paying claims with respect to the insured Component Benefits.
In contrast, the University is responsible for paying claims with respect to the self-funded
Component Benefits from its general assets.
Contributions for any coverage under the Plan may be made solely by the University or by joint