Summary Plan Description
for the University of Notre Dame du Lac
Group Benefits Plan

Effective January 1, 2019

Page

INTRODUCTION TO THIS BOOKLET

This booklet summarizes certain benefits provided under an employee welfare benefit plan called the University of Notre Dame du Lac Group Benefits Plan (the "Plan"). You may notice that certain words throughout this Summary are capitalized. This indicates that they have a special meaning and are defined in the back of this booklet. This booklet describes those benefits available to Eligible Employees and their families. The eligibility requirements are described throughout this booklet in the sections describing particular benefits.

If you have any questions after reading this Summary, please contact The Office of Human Resources. This booklet applies only to eligible employees and eligible dependents who are covered under the Plan as of January 1, 2019. Coverage of individuals under the Plan prior to January 1, 2019 is governed solely by the summary plan description in effect prior to January 1, 2019.

LEGAL INFORMATION

This information about your benefits is provided in compliance with the Employee Retirement Income Security Act of 1974, as amended, and the regulations promulgated thereunder (ERISA). You should not need these details on a regular basis; however, the information may be useful if you have specific questions about your benefits.

Plan Name

There is a separate legal entity called the "Plan" that provides the benefits described in this booklet. It is the University of Notre Dame Du Lac Group Benefits Plan (the "Plan").

Sponsor Name and Address

The Plan Sponsor is:

UNIVERSITY OF NOTRE DAME DU LAC
100 GRACE HALL
NOTRE DAME, INDIANA 46556-5612

Plan Administrator

The Plan Administrator is the person, persons or entity identified in the DEFINITIONS section of this booklet. Generally, the Plan Administrator is responsible for all aspects of the Plan's operations; however, certain portions of the Plan are administered by a Third Party Administrator who has been delegated responsibility for interpreting those portions of the Plan. If a Third Party Administrator has been delegated authority to administer a portion of the Plan, it will be explained in the Explanation of Coverage for that portion of the Plan.

Type of Administration

The Plan is administered by the Plan Administrator, who has full responsibility to control and manage the operation of the Plan. The Plan Administrator may delegate any of its administrative duties to a person or a firm out of necessity or convenience.

The Plan Administrator (Plan Sponsor) is responsible for all other aspects regarding the management, operation and control of the Plan, unless it has delegated a duty to another person or entity. The Plan Sponsor has delegated certain administrative responsibilities for certain types of benefits to a Third Party Administrator (TPA). If there is a TPA for a particular benefit, that TPA will be listed in Appendix A to this Summary.

The TPA decides and administers benefits claims, and assists the Plan Administrator in preparing the documents necessary to fulfill the company's ERISA and IRS reporting and disclosure requirements. The TPA is also your first point of contact if you have questions

regarding your benefits. The TPA has a designated representative assigned to answer questions regarding Plan benefits for employees and their families.

Some of your benefits may be fully insured. That is, an insurance company contracts with the Plan Sponsor to provide benefits and is solely responsible to pay your benefits. Each insurance carrier that provides an insured benefit to the Plan is responsible for the control, management and operation of the Plan with respect to the insured benefit such carrier provides and acts as the TPA. If a benefit is fully insured, it is listed as such on Appendix A to this Summary, as is the insurance company responsible for providing that benefit.

Other benefits are provided on a self-funded basis, which means the Plan Sponsor pays for these benefits as needed. If a benefit is self-funded, it is listed as such in Appendix A to the Summary.

Agent for Service of Legal Process

The name and address of the designated agent for service of legal process is:

The University of Notre Dame du Lac
100 Grace Hall
Notre Dame, IN 46556

Service of legal process may be made upon a plan trustee or the Plan Administrator.

Identification Numbers

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to the Plan Sponsor is 35-0868188.

Plan Year

The Plan Year begins on January 1 and ends on December 31.

Plan Records

Plan records are kept on a Plan Year basis.

Plan Number

The Plan has been assigned Plan #501. All of your benefits are provided under this plan number.

Plan Funding

Depending on the coverage you choose, some of your benefits may be provided through a self-funded plan. That is, the Plan Sponsor, rather than an insurance company, pays your benefits and a Third Party Administrator administers your benefits.

Other benefits are paid by an insurance company. For those insured benefits, the Employer's only financial obligation is to pay its share of the premiums and to forward Employee premiums to the insurance company. That means that the insurance company is solely responsible for paying benefits you are owed. The name, address and the role of each insurance company involved with the Plan are provided in your Explanation of Coverage for each benefit and in Appendix A to this Summary.

Whether a benefit is fully-insured or self-funded is described in Appendix A to this Summary.

You may be required to contribute to your benefit costs. The exact amount of your contributions will be provided to you by your Employer from time to time. Your actual contributions, if any, will be determined according to the cost of the benefits you choose. Other costs associated with your benefits, such as coinsurance amounts or deductibles, can be found in your Explanation of Coverage.

Plan Document

This Summary is intended to help you understand the main features of the Plan. It should not be considered a substitute for the Plan Document, which governs the operation of the Plan. The Plan Document sets forth all of the details and provisions concerning the Plan and is subject to amendment. If any questions arise that are not covered in this Summary Plan Description or if this Summary Plan Description appears to conflict with the official Plan Document, the text of the official Plan Document will determine how questions will be resolved.

Right to Amend/Terminate the Plan

The University of Notre Dame has the power to alter, amend or terminate the Plan with respect to the benefits eligibility and entitlement of any group or class of Employees, at any time. In the event of Plan termination, Employees may have the option to convert any insured benefits they have to individual policies. For a detailed explanation of these conversion rights, if any, you should review the applicable Explanation of Coverage that describes these benefits.

Qualified Medical Child Support Order

Participants and beneficiaries in the Plan may obtain, without charge, a copy of procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

Plan Interpretation and Administration

To the fullest extent permitted by law, the Plan Administrator will have the exclusive discretion to determine all matters relating to eligibility, coverage and benefits under the Plan. The Plan Administrator will also have the exclusive discretion to determine all matters relating to interpretation and operation of the Plan. The Third Party

Administrator has the initial authority to make benefits eligibility, coverage and benefit determinations for those benefits that are self-insured, although the Plan Administrator has the final decision-making authority. For insured benefits, the insurance carrier or provider acts as a Third Party Administrator and makes these decisions, which are not subject to the Plan Administrator's review.

The Plan Administrator can perform personally or through another person it designates, including a Third Party Administrator, the administrative functions described in this section. The Plan Administrator will control and manage the operation and administration of the Plan. These duties include, but are not limited to: its duty to construe and interpret the Plan; adopt and enforce rules and procedures to administer the Plan; to decide all questions regarding eligibility for participation; to prescribe procedures to be followed by participants filing applications for benefits; to prepare and distribute to participants information explaining the Plan; and to determine the amount, manner and time of payment of any benefits of the Plan. Any determination made or action taken by the Plan Administrator is conclusive with respect to you or any other individual to whom the determination or action relates. Such determination or act may, however, be reversed by a court of competent jurisdiction, but only on a finding by the court that the Plan Administrator's action or determination was arbitrary and capricious.

No Contract or Guarantee

Please be aware that receipt of this Summary Plan Description does not imply eligibility for the Plan. Please contact the Plan Administrator or Third Party Administrator with any questions. In addition, this Summary Plan Description does not constitute an implied or express contract or guarantee of employment.

Claims Procedures

Depending on the type of benefit involved, there are specific rules for how to submit a claim for benefits. Those specific rules are described in your Explanation of Coverage, as well as in other sections throughout this booklet. This section of your booklet describes certain general rules that apply regardless of the type of benefit involved. However, this booklet contains only a general and brief overview of the claims procedures that may be applicable to the benefits you are claiming. If these general rules in this section of the booklet conflict with those outlined in other sections of this booklet that describe procedures for claiming specific benefits, the procedures in those more specific sections of this booklet prevail. If either the general procedures in this section or the procedures in other sections of this booklet conflict with the procedures outlined in the Explanation of Coverage, the procedures in the Explanation of Coverage prevail.

If any claim for benefits you file is denied, you will be notified in writing of the decision within ninety (90) days after submission. Certain health claims will be decided within shorter periods of time. These claims, such as those involving urgent medical benefits, are decided sooner in order to better serve your health care coverage needs. For detailed

information regarding the time frames for various health and disability claim decisions, please consult your Explanation of Coverage.

Notice regarding the claim denial will include certain specific information about your claim. It will include the reason for denying your claim, references to the applicable provision of the Plan or other Plan related document upon which the denial was based, any additional information you will need to perfect the claim, and why the information is necessary. Any time a claim for benefits is denied, you will also receive an explanation of the Plan's claim review procedures.

Special circumstances may require additional time to process an initial claim. If this occurs, you will be notified in writing of the extension of time and the reason for it within ninety (90) days of submission. Such an extension will be no longer than ninety (90) days.

You have the right to appeal a denial of your claim to a benefit to the Third Party Administrator within one hundred eighty (180) days from the date of denial for the group health plan. (For other benefits, such as vision, provided separately from your major medical benefits, you must appeal within sixty (60) days from the date of denial.) If you do not hear anything about a claim for ninety (90) days, your claim is deemed denied. You may also appoint a representative to assist you in pursuing your claim.

You or your authorized representative, in pursuing your appeal, may request in writing that the Third Party Administrator review the denial, may review pertinent documents, and may submit issues and comments in writing.

The decision on review will be made within sixty (60) days of receipt of the request for review. Some claims on review require more time to process. In such special circumstances, the Third Party Administrator will render a decision within one hundred twenty (120) days of receipt of the request for review. The Third Party Administrator will notify you in writing within sixty (60) days of receipt of the claim if special circumstances require an extension of time. If you do not receive a decision on review, then it is deemed denied.

If Your Claim Is Denied

The Third Party Administrator will notify you in writing or electronically of any claim denial. This notice will tell you why your claim was denied, including reference to the Plan provisions requiring denial. The Plan Administrator will also tell you any additional information it needs to process your claim, as well as the Plan's review procedures and time limits, including your rights under Section 502(a) of ERISA. The Plan Administrator will tell you of any rule or guideline used in the decision, any scientific reason for the denial and the review process applicable to your situation.

If the claim in question involves an urgent medical benefits claim, the Plan Administrator may advise you of his decision orally with written notification following within three (3)

days. You will also receive notice of the expedited review process applicable for urgent care decisions.

Whether or not the benefits decision is adverse, the medical circumstances dictate how quickly the decision on your claim for benefits must be made.

Different Time Frames For Health and Disability Claims

Certain claims for benefits under group health plans must be decided on a shorter time frame. Urgent care claims must be decided within seventy-two (72) hours of receipt of the claim, unless not enough information was provided to make a decision. In that case, the Plan must notify you of the specific information it needs within twenty-four (24) hours of receiving your claim.

If the Plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments (concurrent care claim), then you will be notified of any reduction in the time period or number of treatments with sufficient time to appeal before your benefit is terminated or reduced.

You will be notified of pre-service claim decisions within fifteen (15) days after the Plan receives the claim, with the possibility of an additional fifteen (15) day extension.

Adverse decisions with regard to disability benefits will be decided and you will be notified within forty-five (45) days after the Plan receives the claim. The Plan may extend this time period for an additional thirty (30) days.

Any time the Plan extends its time to make a decision, it will notify you of the extension before the original time period has expired.

If You Would Like to Appeal

You may not agree with the Plan Administrator's decision regarding your claim. If that is the case, you have an opportunity to appeal that decision. Once you receive notice of the decision, you have one hundred eighty (180) days to appeal. You can provide written comments or other evidence for your appeal, and if you request it, you can receive copies of all documents and other information relevant to your claim free of charge.

For medical benefits, different kinds of decisions have different deadlines for the Plan Administrator to decide on appeal.

- Urgent Care Claims - as soon as possible, but within seventy-two (72) hours after receipt of the request for review.
- Pre-Service Claims - not later than fifteen (15) days after receipt of request for review.
- Post-Service Claims - within thirty (30) days of receipt of request for review.

Disability Claims must be decided within forty-five (45) days on review (as opposed to sixty (60) days for medical claims).

Once the Plan Administrator decides your appeal, the Plan Administrator will notify you in writing or electronically. If the decision is adverse, the Plan Administrator must provide you with the following information:

- The specific reason(s) for the determination, including the specific Plan provisions used in the determination. You will also receive information regarding your ability to access and copy free of charge all of the relevant documents and other information relevant to your claim. Your ability to appeal will be outlined for you in detail, including any associated ERISA rights under 502(a).

- Any rules or guidelines used in the determination will be disclosed to you. If the determination was based on medical necessity, the medical and scientific reasons for the decision will be disclosed.

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

If you fail to follow the Plan's procedures for filing a "pre-service claim," you or your representative will be notified. Your notification will include an explanation of the proper procedures for filing a claim for benefits. This notification will be sent to you or your representative no later than five (5) days (or twenty-four (24) hours in the case of an urgent care claim) following the failure. Unless you request written notification, your notification may be oral.

Calculation of Time Limits

To determine the amount of time the Third Party Administrator has to decide your claim or appeal, begin counting the days on the day you file your claim or appeal according to the Plan's procedures.

Right to External Review

If your claim under a health coverage option that is not grandfathered from the requirements of the health care reform act is denied, you may have the right to have that denial reviewed by an external review organization that is independent from the Plan. More information about your external review rights is included in the applicable Explanation of Coverage.

ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under ERISA that 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 work sites and union halls, all Plan Documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. 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 Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or 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 on 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 pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Covered Persons, 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 Covered Persons 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 benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request 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 for reasons beyond the control of the Plan 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; for example, if it finds your claim frivolous.

Assistance with Your Questions

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

HOW TO ENROLL

As soon as you are eligible to participate in the Plan - and then once each Plan Year thereafter - you will be asked to complete enrollment forms so you can elect benefit options for the upcoming Plan Year. The enrollment forms will encompass all benefits for which you are eligible. Certain benefits require you to decide whether you want Employee-only coverage or coverage for your family.

Choose elections carefully. Once you choose, you may not be able to change your election until the next open enrollment period, which leads up to January 1 of every year. In advance of the open enrollment period, you will be provided with online election forms. At that time, you will need to elect your benefit options. At this and any other time, the Third Party Administrator will be available for questions regarding your benefits. The cost of coverage, if any, will be clearly indicated on the enrollment forms.

If You Do Not Enroll

You must return your enrollment forms by the time indicated on your online enrollment forms. If you are a newly hired Employee, you will receive your benefits information on your first day of work. During each annual enrollment, you must return the enrollment forms to The Office of Human Resources by the deadlines shown on the enrollment forms. Failure to do so could cause you to lose your coverages.

You may also opt out of any Employer-sponsored coverage if, for example, you are already covered by a spouse's plan. If you elect not to enroll for medical benefits, you must sign an opt-out form. Opting out of other benefits may require you to sign a waiver of election of benefits. The Third Party Administrator will provide you with the appropriate form, when necessary.

FLEXIBLE BENEFIT PLAN

The Flexible Benefit Plan is a "cafeteria plan" under Section 125 of the Internal Revenue Code. It has two parts. The first part allows Eligible Employees to choose the benefits they receive and the level of coverage they need on a "pre-tax" basis. It allows Eligible Employees the opportunity to elect to apply part of their pre-tax compensation toward the purchase of certain benefits that require Employee contributions. These Eligible Employees receive certain tax advantages because the part of their compensation applied toward the purchase of these benefits under the Pre-Tax Plan is not included in their income and is not subject to income and employment taxes.

Flexible Spending Accounts are another part of the Flexible Benefit Plan. Flexible Spending Accounts allow you to have money deducted from your pay before income and Social Security taxes are withheld and later used to pay for certain types of expenses. The types of Flexible Spending Accounts available to you are described in the summary booklet for the Flexible Benefit Plan. You can use any or all accounts, or you can choose not to participate at all.

If you elect to purchase benefits through the Flexible Benefit Plan, the portion of your compensation that is used to purchase the benefits under this Plan will not be subject to federal, state or local income taxes or FICA (Social Security) taxes. This reduces your level of taxable income, so you pay fewer taxes.

The money you normally receive in your paycheck is subject to FICA (Social Security) taxes. When you chose to direct a portion of your pay to purchase your coverage, you will automatically reduce your salary for FICA (Social Security) tax purposes. This means your Social Security Benefits will be slightly decreased because these benefits are based on the income reported for FICA (Social Security) purposes over your entire working career. However, in most cases the current tax savings derived from these Plans will be considerably more than any possible future reduction in your Social Security Benefits.

Eligibility and Benefits

The eligibility requirements, benefits and other terms and conditions of the Flexible Benefit Plan are described in the summary booklet for the Flexible Benefit Plan.

MEDICAL PLAN

Eligibility

You are eligible for medical coverage (which also includes prescription drug coverage) if you meet the following requirements:

Staff Eligibility

(1) A full-time Staff Employee of the Employer who regularly works 30 or more Hours of Service per week during the academic year for 9 or more months (e.g., an Academic Year Staff Employee) or 30 or more Hours of Service per week during the Calendar Year will be eligible to enroll for coverage under this Plan.

(2) A full-time Staff Employee on an unpaid leave of absence initiated by the Employer, due to organizational requirements of the Employer, will be eligible for coverage if the Employer approves in advance the continuation of coverage during that leave of absence.

For purposes of this Plan, Staff includes the postdoctoral research associates and interns.

Faculty Eligibility

(1) A Full-time faculty will be eligible to enroll for coverage under this plan.

Coverage for full-time regular faculty, as defined in the University's Academic Articles, with an academic year contract will be effective July 1st for contracts with a fall semester start and January 1st for contracts with a spring semester start.

All other full-time faculty will follow the general guidelines for waiting periods to dictate the start date of their benefits.

Full-time faculty on a (J1) visa will not have a waiting period even if they initiate employment during the month.

Participation in the Plan will begin upon completion of the waiting period, if applicable, provided all required election and enrollment forms are properly submitted to the Plan Administrator. When the first day of employment is the first day of the month then there is no waiting period, but if the first day of employment is after the first day of the month then the waiting period is the first day of the following month.

You are not eligible to participate in the Plan if you are a part-time employee, temporary, leased or seasonal employee, an independent contractor or a person performing services pursuant to a contract under which you are designated an independent contractor (regardless of whether you might later be deemed a common law employee by a court or governmental agency).

Determining Full-Time Employee Status for Ongoing Employees: In determining whether an Ongoing Employee is classified as a Full-Time Employee the Employer has set forth a Standard Measurement Period of 12 months followed by a Standard Stability Period of 12 months. If during the Standard Measurement Period, the Ongoing Employee is determined to be a Full-Time Employee, the Plan will have a 60 day Administrative Period to notify the Employee of his or her eligibility (and the eligibility of the Employee's eligible Dependents) to enroll in the Plan and to complete the enrollment process. An Employee who has been determined to be a Full-Time Employee during his or her Measurement Period will be offered coverage that is effective as of the first day of the Employee's Stability Period (and coverage will be offered to such Full-Time Employee's eligible Dependents).

The following applies to an Academic Year Staff Employee: Solely for purposes of computing average Hours of Service for a continuing Employee during any Measurement Period that includes any portion of an "employment break period," a preliminary average will first be determined by disregarding the employment break period. The Employee will then be credited with additional Hours of Service for each Calendar Year equal to the lesser of (i) 501 Hours of Service or (ii) the number of Hours of Service that would be needed for the Employee's average for the entire Measurement Period (disregarding special unpaid leave as defined in the preceding paragraph) to equal the preliminary average. The Employee's final average, which will be used to determine if the Employee is a Full-Time Employee will then be determined by dividing the total Hours of Service credited by the length of the Measurement Period (disregarding special unpaid leave).

Determining Full-Time Employee Status for New Variable Hour or Part-Time Employees: In determining whether a new Variable Hour or Part-Time Employee will be considered as a Full-Time Employee during the Initial Stability Period, the Employer has set forth an Initial Measurement Period of 12 months followed by an Initial Stability Period of 12 months. If during the Initial Measurement Period, the Employee is determined to be a Full-Time Employee, the Plan will have a 60 day Administrative Period to notify the Employee of his or her eligibility to enroll in the plan and to complete the enrollment process (and the eligibility of the Employee's eligible Dependents).

An Employee who has been determined to be a Full-Time Employee during his or her Measurement Period will be offered coverage that is effective as of the first day of the Employee's Stability Period (and coverage will be offered to such Full-Time Employee's eligible Dependents). Notwithstanding any other provision to the contrary, the combined

length of the Initial Measurement Period and the Administrative Period for a New Employee who is a Part-Time, Variable Hour or Seasonal Employee may not extend beyond the last day of the first calendar month beginning on or after the first anniversary of the date the Employee completes at least one Hour of Service with the Employer.

Material Change in Position or Employment Status for New Variable Hour or Part-Time Employee: An Employee who, during his or her Initial Measurement Period, experiences a material change in position or employment status that results in the Employee becoming reasonably expected to work at least 30 Hours of Service per week for the Employer will be treated as a Full-Time Employee to whom coverage under the Plan will be offered to the Employee and his or her eligible Dependents beginning on the earlier of:

(1) The 4th full calendar month following the change in employment status; or

(2) The first day of the Initial Stability Period (but only if the Employee averaged at least 30 Hours of Service per week during the Initial Measurement Period).

Retiree Eligibility

(1) An employee who is eligible to retire, has ten (10) years of service with the Employer after the age of 45, retires directly from active service, and is currently covered by the Employer's medical insurance.

(2) Is a disability retiree of the Employer under age 55.

Your dependents are eligible for medical coverage if they meet the definition of an eligible dependent as described in the Explanation of Coverage. Please consult the Explanation of Coverage with any questions regarding dependent eligibility.

Cost

Your contributions toward the cost of coverage, if any, will be deducted from your pay and are subject to change. The rate of any required contributions will be determined by your Employer and communicated to you from time to time. Adding and deleting dependents may affect the amount of your contributions.

Description of Benefits

For a detailed description of the benefits available under your medical coverage, please consult your Explanation of Coverage. There is a separate Explanation of Coverage that describes your prescription drug benefits. These Certificates include all of the information about your benefits you need to make informed decisions regarding your care. However, please contact the Third Party Administrator if you have questions.

DENTAL PLAN

Eligibility

Staff Employee Eligibility. A full-time Staff Employee of the Employer who regularly works 30 or more hours per week during the academic year for nine (9) or more months or 30 hours per week during the Calendar Year for twelve (12) months will be eligible to enroll for coverage under this Plan. For purposes of this Plan, Staff includes the postdoctoral research associates and interns.

Faculty Employee Eligibility. A full-time regular faculty or visiting faculty as defined in the University's Academic Articles will be eligible to enroll for coverage under this Plan. Coverage for faculty will be effective July 1st (including teaching and research, special professional faculty and research) with an August 22nd contract and a July 1st pay and benefit schedule. Coverage for visiting faculty will be effective August 1st with an August 22nd contract and an August 1st pay and benefit schedule.

Participation in the Plan will begin upon completion of the waiting period, if applicable, provided all required election and enrollment forms are properly submitted to the Plan Administrator. When the first day of employment is the first day of the month then there is no waiting period, but if the first day of employment is after the first day of the month then the waiting period is the first day of the following month.

You are not eligible to participate in the Plan if you are a part-time employee, temporary, leased or seasonal employee, an independent contractor or a person performing services pursuant to a contract under which you are designated an independent contractor(regardless of whether you might later be deemed a common law employee by a court or governmental agency).

Special rules for determining eligibility for coverage on the basis of an employee's full-time status are described in the Medical Plan section of this Summary.

Your dependents are eligible for dental coverage if they meet the definition of an eligible dependent as described in the Explanation of Coverage. Please consult the Explanation of Coverage with any questions regarding dependent eligibility.

Cost

Your contributions toward the cost of coverage, if any, will be deducted from your pay and are subject to change. The rate of any required contributions will be determined by the Employer and communicated to you from time to time. Adding and deleting dependents may affect the amount of your contributions.

Description of Benefits

This benefit is designed to help take care of your dental care needs. The services provided may include preventative services, restorative services, and orthodontia. For specific information about your dental services and any copayments or coinsurance amounts you may be required to pay, see your Explanation of Coverage.

VISION PLAN

Eligibility

Staff Employee Eligibility. A full-time Staff Employee of the Employer who regularly works 30 or more hours per week during the academic year for nine (9) or more months or 30 hours per week during the Calendar Year for twelve (12) months will be eligible to enroll for coverage under this Plan. For purposes of this Plan, Staff includes the postdoctoral research associates and interns.

Faculty Employee Eligibility. A full-time regular faculty or visiting faculty as defined in the University's Academic Articles will be eligible to enroll for coverage under this Plan. Coverage for faculty will be effective July 1st (including teaching and research, special professional faculty and research) with an August 22nd contract and a July 1st pay and benefit schedule. Coverage for visiting faculty will be effective August 1st with an August 22nd contract and an August 1st pay and benefit schedule.

Participation in the Plan will begin upon completion of the waiting period, if applicable, provided all required election and enrollment forms are properly submitted to the Plan Administrator. When the first day of employment is the first day of the month then there is no waiting period, but if the first day of employment is after the first day of the month then the waiting period is the first day of the following month.

You are not eligible to participate in the Plan if you are a part-time employee, temporary, leased or seasonal employee, an independent contractor or a person performing services pursuant to a contract under which you are designated an independent contractor(regardless of whether you might later be deemed a common law employee by a court or governmental agency).

Special rules for determining eligibility for coverage on the basis of an employee's full-time status are described in the Medical Plan section of this Summary.

Your dependents are eligible for vision coverage if they meet the definition of an eligible dependent as described in the Explanation of Coverage. Please consult the Explanation of Coverage with any questions regarding dependent eligibility.

Cost

Your contributions toward the cost of coverage, if any, will be deducted from your pay and are subject to change. The rate of any required contributions will be determined by the Employer and communicated to you from time to time. Adding and deleting dependents may affect the amount of your contributions.

Description of Benefits

This benefit is designed to help take care of your vision care needs. For the exact services provided in your vision benefit and for the percentage of the cost you will be required to pay under this Plan, see your Explanation of Coverage.

LIFE INSURANCE

Eligibility

You are eligible for life insurance coverage if you meet the following requirements:

- You are full-time faculty, exempt or non-exempt staff.
- Dependent coverage - Eligible family members include a spouse and any unmarried dependent child(ren) under age 19 as well as any unmarried child(ren) between the ages of 19 and 25 who are full-time students and considered dependent(s).
- You are eligible in the plan on the first day of the month coinciding with or next following the Employee's date of hire.

Cost

The costs associated with your life insurance benefits will be communicated to you by the University. Any required contributions toward the cost of coverage will be deducted from your pay and are subject to change.

Description of Benefits

The amount of your benefit and a description of coverage are included in your Explanation of Coverage.

LONG TERM DISABILITY INSURANCE

Eligibility

You are eligible for long term disability insurance coverage if you meet the following requirement:

- After one year of employment, eligible faculty and staff are regular staff working at least 20 hours per week.

Cost

The costs associated with your long term disability insurance benefits will be communicated to you by your Employer. Any required contributions toward the cost of coverage will be deducted from your pay and are subject to change.

Description of Benefits

For a detailed explanation of this benefit, including its limitations, reductions and exclusions, please consult your Explanation of Coverage.

LONG TERM CARE INSURANCE

Eligibility

- Prudential is no longer offering enrollment into the plan.
- If you are a current certificate holder, you remain eligible for this group coverage as long as you are:
    - An Employee or Retiree of University of Notre Dame du lac; or
    - Related to an Employee in one of the following ways:
        - You are a spouse of the Employee.
        - You are the parent or grandparent of the Employee or the Employee's spouse.
        - You are the spouse of the parent or grandparent.
        - You are the adult child of an Employee or the adult child's spouse.
        - You are the surviving spouse of a deceased retiree.
    - Related to the Retiree in one of the following ways:
        - You are the spouse of a Retiree.
        - You are the surviving spouse of a deceased Retiree.
    - You must be at least 18 but less than age 85 when your enrollment form is completed.

Costs

Premiums for this coverage are based on your age as of the date you enroll for Coverage and the Coverage option(s) you have chosen. Premiums may change on a class basis to all insureds. You will be charged an additional premium if you choose to increase your benefits.

Description of Benefits

For a detailed explanation of this benefit, including its limitations, reductions and exclusions, please consult your Explanation of Coverage.

DEFINITIONS

Employee(s)/ Eligible Employees are employees of the Employer who are included in any Eligible Class and meet any hours of work and waiting period requirements described in the Explanation of Coverage. Different benefits may have different eligibility requirements.

Employer refers to the Plan Sponsor and each of its affiliates that has adopted this Plan.

Explanation of Coverage is the informational booklet that you receive from your insurance company or third party administrator that describes your benefit.

Flexible Benefit Plan means the University of Notre Dame du Lac Flexible Benefit Plan.

Plan describes your employee welfare benefit plan. It is University of Notre Dame du Lac Group Benefits Plan.

Plan Administrator is the person or entity who is legally responsible for administering your benefits and determining what claims should be paid. The Plan Administrator is The University of Notre Dame du Lac.

Plan Document represents the compiled provisions of the Plan. It is the Plan itself, rather than a summary of the Plan provisions. It is the legal document that controls the operation of the Plan and the payment of benefits to covered persons.

Plan Year is the 12-month period of time for which benefits are administered and for which Plan records are kept.

SPD is the "Summary Plan Description." The SPD describes the benefits available under the Plan. The SPD is also referred to as the "Summary."

Sponsor refers to University of Notre Dame du Lac.

Third Party Administrator or TPA is the contracted outside party who is responsible for the administration of benefits under the Plan. The TPA is responsible for answering routine questions from Employees and other Covered Persons about their benefits and should be your first point of contact.

APPENDIX A

- Group health coverage (including Notre Dame Wellness Center) self-funded and administered by Anthem Blue Cross Blue Shield. This coverage also includes prescription drug coverage self-funded and administered by OptumRx, Inc.
- Group dental coverage insured and administered by Delta Dental.
- Group vision coverage insured and administered by EyeMed.
- Group life insurance coverage insured and administered by Securian Financial.
- Group long-term disability coverage insured and administered by The Hartford.
- Health Flexible Spending Accounts -- self-funded and administered by Anthem Blue Cross Blue Shield.
- Dependent Care Flexible Spending Accounts -- self-funded and administered by Anthem Blue Cross Blue Shield.
- Group long-term care coverage -- insured and administered by The Prudential Insurance Company of America.

Addresses, phone numbers and other contact information for theses insurance companies and third party administrators can be found in the applicable Explanation of Coverage.