

**THE UNIVERSITY OF AKRON
HEALTH REIMBURSEMENT ARRANGEMENT
SUMMARY PLAN DESCRIPTION**

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HEALTH REIMBURSEMENT ARRANGEMENT

We are pleased to establish this Health Reimbursement Arrangement to provide you with additional health coverage benefits. The benefits available under this Plan are outlined in this summary plan description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you become eligible and the laws that protect your rights.

Read this summary plan description carefully so that you understand the provisions of our Plan and the benefits you will receive. You should direct any questions you have to the Administrator. There is a plan document on file, which you may review if you desire. In the event there is a conflict between this summary plan description and the plan document, the plan document will control.

I ELIGIBILITY

1. What Are the Eligibility Requirements for Our Plan?

You will be able to join the Plan once you have satisfied the conditions for eligibility under the Voluntary Early Retirement Incentive Plan.

2. When is My Entry Date?

You can join the Plan July 1, 2018 following your exit from The University of Akron on or before May 31, 2018 by way of the Voluntary Early Retirement Incentive Plan.

3. Are There Any Participants Who Are Not Eligible?

Yes, there are certain participants who are not eligible to join the Plan. They are:

Those not enrolled in the Voluntary Early Retirement Incentive Plan

II BENEFITS

1. What Benefits Are Available?

This plan will reimburse you for the following expenses:

- Medical, dental, and vision insurance premiums
- Medical expenses
- Dental expenses
- Vision expenses
- Prescription expenses
- Other medical expenses covered by section 213(d) of the Internal Revenue Code. A list of some of the expenses that qualify is available from the Administrator

The maximum amount you are allowed to be reimbursed up to during the Coverage Period is the following:

Single

You will be reimbursed up to \$4000 for eligible expenses.

Family

You will be reimbursed up to \$4000 for eligible expenses.

If you have amounts remaining in your account at the end of the coverage period, these amounts will carry forward into the next coverage period to be used for future eligible expenses. The cumulative maximum amount you can have in your account is \$16,000.

We will provide you a debit card to use to pay for your eligible expenses under this plan. The Administrator will provide you with further details.

Any amounts reimbursed to you under the Plan may not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage including our health flexible spending account. You must first use all amounts in this Plan before submitting any claims to our health flexible spending account plan.

You may submit expenses for yourself, your spouse and your children. You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption.

2. When Must Expenses Be Incurred?

You may submit expenses that you incur each "Coverage Period." A new "Coverage Period" begins each Plan Year. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

3. When Will I Receive Payments From the Plan?

During the course of the Coverage Period, you may submit requests for reimbursement of expenses you have incurred. However, you must make your requests for reimbursements no later than 90 days after the end of the Plan Year. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. In addition, you must submit Explanation of Benefit (EOB), Pharmacy Receipt, Provider Receipt and other documentation to the Administrator as proof of the expenses you have incurred and that they have not been paid by any other health plan coverage. Premiums must be submitted for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, reimbursements made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

4. What Happens If I Lose Eligibility?

If you lose eligibility to participate in the Plan during the Plan Year for any reason, your participation in the Plan will cease. You may submit claims for eligible expenses that were incurred while were an active participant as follows:

90 days after the date of loss of eligibility

5. Can I Opt Out of the Plan?

Yes, you can once a plan year, opt out of the Plan and receive no further reimbursement.

6. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

7. Newborns' and Mothers' Health Protection Act

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

8. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

III GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information, which you may need to know about the Plan.

1. General Plan Information

Health Reimbursement Arrangement (HRA) is the name of the Plan.

Your Employer has assigned Plan Number 510 to your Plan.

The provisions of your Plan become effective on 07/01/2018.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on 07/01 and ends on 06/30.

2. Employer Information

Your Employer's name, address, and identification number are:

The University of Akron
302 Buchtel Commons
Akron, OH 44325
34-6002924

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

The University of Akron
302 Buchtel Commons
Akron, OH 44325
(330) 972-5146

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. The Plan Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding. You may contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

The University of Akron
302 Buchtel Commons
Akron, OH 44325
(330) 972-5146

5. Type of Administration

The Plan is a health reimbursement arrangement and Employer is the Plan Administrator. The Plan Administrator may provide the claims administration through a Third Party Claims Administrator. The Plan is not funded or insured. Benefits are paid from the general assets of the Employer.

6. Third Party Claims Administrator Information

The name, address and business telephone of the Third Party Claims Administrator are:

Chard Snyder
6867 Cintas Blvd
Mason, OH 45040
(513) 459-9997

The Third Party Claims Administrator is responsible for the actual processing of claims on behalf of the Plan Administrator.

IV ADDITIONAL PLAN INFORMATION

1. How to Submit a Claim

When you have a claim to submit for payment, you must:

- (a) Obtain a claim form from the Plan Administrator.
- (b) Complete the Participant portion of the form.
- (c) Attach copies of all bills from the service provider for which you are requesting reimbursement.

A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

Notification of whether claim is accepted or denied 30 days

Extension due to matters beyond the control of the Plan 15 days

Insufficient information to process the claim:

Notification to Participant 15 days

Response by Participant 45 days

Review of claim denial 60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

- (a) The specific reason or reasons for the denial.
- (b) Reference to the specific Plan provisions on which the denial was based.
- (c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- (d) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and
- (e) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

- (a) was relied upon in making the Claim determination;
- (b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- (c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants;
- (d) or constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a Plan Sponsor of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.