Rivier University

Wellness Plan

Summary Plan Description

January 1, 2015
Introduction

Rivier University (the “Company”) maintains the Rivier University Wellness Plan (the “Plan”) for the exclusive benefit of its eligible employees and their eligible dependents. The Plan is a wellness plan designed to assist eligible employees to improve their health and wellness. Benefits under the Plan are provided through an agreement between the Company and Orriant.

The benefits are summarized in materials provided by ORRIANT. This document, and the summary provided by ORRIANT constitute the Summary Plan description (“SPD”) required by federal law known as the Employee Retirement Income Security Act of 1974 (“ERISA”).

Specific Plan Information

Plan Name: Rivier University Wellness Program

Type of Plan: A health and welfare plan (a type of welfare benefits plan subject to the provisions of ERISA).

Plan Year: January 1 – December 31

Plan Sponsor: Rivier University
420 South Main Street
Nashua, NH 03060

Plan Funding and Type of Administration: The Plan is funded by the Company on a pay as go basis. Wellness benefits are provided under a contract between the Company and ORRIANT.

Plan Sponsor’s Employer Identification Number: 02-0223339

Plan Administrator: Rivier University
420 South Main Street
Nashua, NH 03060
(603) 897-8717

Agent for Service of Legal Process: Rivier University
420 South Main Street
Nashua, NH 03060
Important Disclaimer:

Plan benefits are provided under contracts between the Company and ORRIANT. If the terms of this summary document conflict with the terms of these contracts, the contracts will control.

Eligibility

You are eligible to participate in the Plan if you are a participant in the Company sponsored health benefits plan. If eligible, you must complete application forms to enroll in the Plan (available from your Human Resources Department).

Your eligibility for Plan benefits terminates when your eligibility for benefits under the Company Sponsored health benefits plan terminates

Summary of Plan Benefits

A summary of health benefits provided under the Plan is provided in the Program Summary provided by ORRIANT.

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discriminating among them.

The Plan Administrator is responsible for determining eligibility for the Plan. The benefits available are pursuant to the contract with ORRIANT. In the event of a dispute with respect to the entitlement to wellness benefits, the Company will make the decision.

Claims and Appeals

The Plan Administrator is responsible for evaluating benefit claims under the Plan. The Plan Administrator will decide your claim in accordance with the following claims procedures:

Within 30 days after receipt by the Plan Administrator of a claim from a Participant, the Participant be advised whether he or she will receive the discount on his/her insurance premium (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended for an additional fifteen (15) days for matters beyond the control of the Plan Administrator, including cases where a claim submitted by the Participant is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension,
and will allow the Participant an additional forty-five (45) days in which to complete an incomplete claim. If any claim for benefits under this Plan is denied in whole or in part, the Plan Administrator shall furnish the claimant promptly with a written notice:

(a) Setting forth the reason for the denial;

(b) Citing the Plan provisions upon which such denial is based;

(c) Describing any additional material or information from the claimant which is necessary in order for the claimant to perfect his or her claim and why; and

(d) Explaining the claim review procedure set forth herein.

Time periods begin when the claim is filed without regard to whether the information is complete. If the period is extended because of missing information, the time period for decisions is “tolling” when the notice of extension is sent.

If a claim is denied, the Participant has up to one hundred eighty (180) days to appeal that decision. The Plan must respond to the appeal request by no later than sixty (60) days or thirty (30) days each, if two appeals are required by the Plan.

The review on appeal will be made by a three-member “Benefits Committee” appointed from time to time by the Plan Sponsor which shall not include any person involved in making the initial claims denial decision, or anyone who is a subordinate of the original decision maker. The review on appeal will be an original review. That is, the appeal review will not give any weight to the initial denial, and will take into account all information submitted by the Participant, regardless whether it was submitted or considered in the initial decision denying the claim. In deciding an appeal of an initial decision based wholly or partly on medical judgment (including decisions about whether a particular item or service is experimental, investigational or not medically necessary or appropriate), the individual reviewing the decision on appeal must consult with a qualified health care professional who was not consulted in connection with the initial adverse claims decision that is the subject of the appeal.

The Participant will not be required to file more than two appeals of his or her claim as a condition to filing a civil suit for benefits under ERISA Section 502(a). One of these appeals may be an arbitration, however, any arbitration will be non-binding. The Plan may offer additional voluntary levels of appeal such as arbitration or other forms of alternative dispute resolution only after the required appeal process is exhausted. An election to undertake a voluntary appeal will not affect Participant rights to any other Plan benefits. No fees or costs will be imposed for filing or appealing any claim for benefits under these Plan appeal procedures.
The Plan Administrator, or its designated agent, or the Benefits Committee, or its designated agent, as the case may be, shall have complete authority to determine the standard of proof required in any case and to apply and interpret the Plan document. The decisions of the Plan Administrator, the Benefits Committee or their agents or delegates shall be final and binding. All questions or controversies, of whatsoever character, arising in any manner or between any parties or persons in connection with this Plan or its operation whether as to any claim for benefits, or as to the construction of language or meaning of the Plan document, or as to any writing, decision, instrument or account in connection with the operation of the Plan or otherwise, shall be submitted to the Plan Administrator for such decision. The decision of the Plan Administrator shall be binding upon all persons dealing with the Plan or claiming any benefit hereunder, except to the extent that such decision may be appealed to the Benefits Committee or be determined to be arbitrary or capricious by a court having jurisdiction over such matters.

**Amendment or Termination of the Plan**

As Plan Sponsor, the Company has the right to amend or terminate the Plan at any time.

**No Contract of Employment**

The Plan is not intended to, and does not either directly or indirectly, constitute any form of employment contract or other employment arrangement between you and the Company.

**Statement of ERISA Rights**

**Your Rights**

As a Participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all participants shall be entitled to:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites, all documents governing the plan and a copy of the latest annual report (Form 5500 Series), if any, 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, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including any collective bargaining agreements, and an 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 any required summary annual report.

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participation, ERISA imposes duties on 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 you in any way to prevent you from obtaining a plan 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 these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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. Using the administrative appeal procedure is necessary before a lawsuit may be filed.

If it should happen that a fiduciary misuses 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 (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

**No Discrimination**

No one, including the Plan Sponsor or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining welfare benefits or exercising your rights under ERISA.
Right to Review

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan Administrator, or its designee, review and reconsider your claim.

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 HIPAA, 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 on the Department of Labor’s website at http://www.dol.gov/ebsa/aboutebsa/org_chart.html#section13, 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.