UNIVERSITY OF NEW ENGLAND
EMPLOYEE BENEFIT PLAN

PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION

Restated Effective January 1, 2025

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GENERAL INFORMATION

Plan Name: University of New England Employee Benefit Plan

Plan Sponsor: University of New England
11 Hills Beach Road
Biddeford, ME 04005

Plan Number: 501

Plan Type: Welfare benefit plan providing medical, dental, vision, health flexible spending account, life insurance, accidental death and dismemberment, short-term disability, long-term disability, business travel accident insurance, cancer insurance, critical illness insurance, accident insurance, and employee assistance program benefits. The Plan also includes the University of New England Flexible Benefit Plan, a plan governed by Code Section 125, which is not subject to ERISA.

Employer Identification Number: 01-0211810

Restatement Effective Date: January 1, 2025

Plan Year: January 1 to December 31

Plan Administrator: University of New England
11 Hills Beach Road
Biddeford, ME 04005
207-602-2394

Agent for Service of Legal Process: University of New England
11 Hills Beach Road
Biddeford, ME 04005
Service may be made upon the plan administrator.

PURPOSE OF THE PLAN

University of New England maintains the University of New England Employee Benefit Plan (the "Plan") for the exclusive benefit of its Eligible Employees and their eligible family members. The Plan provides health and welfare benefits through the component benefit programs ("Benefits") listed in Appendix A, each of which is described in separate attachments.

Each of the Benefits is described in a separate written document, insurance certificate or contract, benefit summary, or other governing document. The Benefits documents together with this document constitute the written plan and summary plan description.

This document is intended to serve as both a plan document and as a summary plan description for the Plan. **In general, the terms of the written Benefit documents control claims for benefits under the component benefit programs. In the event that the terms of this booklet conflict with the written Benefit documents, then the terms of the written Benefit documents will control, except with respect to provisions regarding eligibility to participate in a Benefit and unless otherwise required by law. You should read the Benefit documents and this document together carefully to understand your benefits.**

DEFINITIONS

Whenever used in the Plan the singular includes the plural and the following capitalized terms have the following meanings, unless a different meaning is clearly required by the context:

"Benefits" means, generally, the medical, dental, vision, Medical Flexible Spending Account, life insurance, accidental death and dismemberment, short-term disability, long-term disability, business travel accident insurance, cancer insurance, critical illness insurance, accident insurance and employee assistance program benefits. See Appendix A at the end of this document for a detailed list of the particular Benefits offered through the Plan. The Benefits will be provided by the applicable policy, not the Plan. Information about the Benefits may be found in a separate written plan document, insurance certificate or contract, benefit summary, or other governing document for each Benefit.

"Code" means the Internal Revenue Code of 1986, as amended.

"Dependent" means: (1) your (or your Spouse's or Domestic Partner's) biological child, stepchild, legally adopted child, child who is placed in your home for adoption, or child for whom you are appointed as legal guardian who is chiefly dependent on you for support and maintenance; who is under age 26, regardless of their marital status, student status, whether they live with you, or whether you provide any of their support; (2) your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on your for support, provided that the child was disabled prior to age 26 (the Plan Administrator may require you to provide appropriate documentation of the child's disability); and (3) children for whom the Plan is required to provide coverage under a Qualified Medical Child Support Order.

"Domestic Partner" means a person who meets all of the following requirements:

- You have shared the same household for at least 6 consecutive months and you intend to continue to do so indefinitely.
- You have registered as a domestic partnership (if required under state law).
- You are engaged in a committed relationship of mutual caring and support and intend to remain so indefinitely.
- You share responsibility for each other's common welfare and living expenses.
- You share financial interdependence.
- You consider yourselves to be life partners.
- Neither you, nor the person, is married (as defined by state law) to, or in a committed relationship with, or legally separated without a dissolution of marriage from, anyone else.
- You have not had another Domestic Partner enrolled in the Plan within the prior 12 months.
- You both have reached the age of majority and are mentally competent to consent to a contract.
- You are not related by blood to a degree or closeness that would prohibit marriage.
- You are not in the relationship primarily for the purpose of obtaining health care coverage.
- You have not previously been legally married to each other while covered under the Plan.

Before a person will be eligible for benefits as a Domestic Partner, you must submit, and the Plan must accept, a complete Domestic Partnership Declaration. A copy of this form is available from the Plan Administrator. The Plan Administrator may request appropriate documentation or evidence of the required relationship in order to administer the requirements set forth above.

"Eligible Employee" means an Employee who meets the requirements described in the "ELIGIBILITY AND ENROLLMENT" section and who is therefore eligible to participate in the Plan.

"Employee" means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, including an Employee who is a shareholder of the Employer. However, the term "Employee" does not include: (a) a student currently enrolled at the Employer; (b) any leased employee, or an individual classified by the Employer as a contract worker, independent contractor, or casual employee, whether or not that individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (c) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which the individual is paid by the agency, whether or not the individual is determined by the IRS or others to be a common-law employee of the Employer; (d) any employee covered under a collective bargaining agreement; (e) any self-employed individual; (f) any partner in a partnership; and (g) any more-than-2% shareholder in a Subchapter S corporation. The term Employee includes former Employees for the limited purpose of allowing continued eligibility for benefits under the Plan

for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided under the Plan.

"Employer" means University of New England and any member of its controlled group that adopts the Plan with the approval of University of New England. For purposes of the "Plan Administrator," "Insurance Contracts," and "Amendment and Termination" paragraphs, however, "Employer" means only University of New England.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"Participant" means an Eligible Employee or retiree who is participating in the Plan in accordance with the provisions of the "ELIGIBILITY AND ENROLLMENT" section.

"Plan" means the University of New England Employee Benefit Plan as set forth in this document and as amended from time to time.

"Plan Administrator" means the Employer or the person, persons, or business organization designated by the Employer to oversee the administration of the Plan.

"Spouse" means the person to whom you are legally married, as determined under federal law.

ELIGIBILITY AND ENROLLMENT

Eligibility

An "Eligible Employee" with respect to the Plan is any Employee who is eligible to participate in and receive benefits under one or more of the Benefits in accordance with the terms and conditions of the applicable Benefit, as described in Appendix A below. Generally, if you are eligible for a benefit, your Spouse, Domestic Partner, and Dependents are also eligible for the benefit. To determine whether you or your family members are eligible to participate in a Benefit, please review Appendix A and the applicable Benefit document.

Not all Eligible Employees, Spouses, Domestic Partners, and Dependents will be eligible to participate in all Benefits available through the Plan. Please contact the Plan Administrator if you have questions regarding your eligibility to participate in a particular Benefit. Spouses, Domestic Partners, and Dependents living outside the United States are not eligible for medical or dental coverage under this Plan, except as provided by the applicable Benefit document.

Need for Enrollment: Time Limits

Enrollment in some of the Benefits may be provided automatically to Eligible Employees, while other Benefits require the completion of annual elections or applications for enrollment. Certain Benefits allow Eligible Employees to pay for their share of the cost of coverage on a pre-tax basis. The details of these administrative requirements are described in the Benefit documents.

The details about pre-tax contributions are described in the University of New England Flexible Benefit Plan.

For Benefits that require enrollment, newly Eligible Employees must generally enroll within certain time periods after being hired or first becoming eligible, as described in the University of New England Flexible Benefit Plan and the Benefit documents. Thereafter, enrollment is generally limited to the annual open enrollment period that occurs before the start of each year, unless circumstances give rise to special enrollment rights described below, or unless other enrollment opportunities are available for a particular Benefit.

Special Enrollment Rights

In certain circumstances, enrollment in the Medical Benefit may be available at times outside the regular open enrollment period (this is referred to as "special enrollment"). The University of New England Flexible Benefit Plan Summary Plan Description and the applicable Benefit documents explain special enrollment rights and the circumstances under which you may change your Benefit elections during the Plan Year.

When Participation Begins

Your coverage under the Plan will begin once you have enrolled in any Benefit. For information about when coverage for a particular Benefit begins, please review the University of New England Flexible Benefit Plan and the applicable Benefit document.

Termination of Participation

In general, your coverage under this Plan terminates on the last day of the month in which you terminate employment with the Employer, unless you are eligible for and elect retiree medical coverage. Coverage under the Plan may also terminate if you fail to pay your share of premiums, if your hours drop below the required eligibility threshold, if you submit false claims, if the Plan terminates, and for certain other reasons described in the Benefit documents.

Coverage for your family members under the Plan stops when your coverage stops, if you fail to provide proof of continued eligibility as may be required by the Plan Administrator, and for other reasons specified in the Benefit documents (for example, divorce or a dependent's attaining age limit).

Coverage under a particular Benefit stops according to the terms and conditions reflected in the Benefit documents. Termination of coverage under a particular Benefit does not necessarily mean your coverage under the Plan in general terminates. You should consult the applicable Benefit documents for specific information.

BENEFITS OFFERED AND METHOD OF FUNDING

Benefits Offered

When first eligible or during the annual enrollment period an Eligible Employee will be given the opportunity to elect to receive one or more of the following Benefits:

1) Medical
2) Dental
3) Vision
4) Medical Flexible Spending Account
5) Life Insurance
6) Accidental Death & Dismemberment
7) Short-Term Disability
8) Long-Term Disability
9) Business Travel Accident Insurance
10) Cancer Insurance
11) Critical Illness Insurance
12) Accident Insurance
13) Employee Assistance Program

The benefits offered through the Plan may change from time to time. Please see Appendix A at the end of this document for a detailed list of the Benefits currently offered through the Plan.

Additional or fewer Benefits may be made available under the Plan from time to time. The Benefits available to Participants are subject to any specification, change or variation under the Plan that relates to the Employer and its Eligible Employees, and certain Benefits may not be available to all Eligible Employees. The terms and conditions of each Benefit are set forth in the separate written plan document, insurance certificate or contract, benefit summary, or other governing document(s) for the particular Benefit. In no event will Benefits under the Plan be provided in the form of deferred compensation or result in the deferral of compensation.

Benefit Funding

In general, the cost of the Benefits will be funded in part by contributions made by the Employer and in part by employee contributions, which may be pre-tax contributions under the University of New England Flexible Benefit Plan. The Employer will determine and periodically communicate your share of the cost of the benefits provided through each Benefit, and it may change that determination at any time.

The Employer will make its contributions in an amount that (in the Employer's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Employer will pay its contribution and your contributions to the insurer. Your contributions toward the cost of a particular Benefit will be used in their entirety prior to using Employer contributions to pay for the cost of the Benefit.

All of the Employer contributions payable under the Plan (including contributions withheld from your paycheck and applied by the Employer to pay for your share of the contributions) will be paid from the general assets of the Employer. Nothing in the Plan will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person will have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under the Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits from its general assets, it may hire an unrelated third-party paying agent to make Benefit payments on its behalf.

Qualified Medical Child Support Orders

The Plan extends rights and privileges under the Benefits to an employee's non-custodial child, as required by any qualified medical child support order (QMCSO), under Section 609(a) of ERISA. The Plan has procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of the QMCSO procedures from the Plan Administrator.

Circumstances That May Affect Benefits

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates. See the above paragraph entitled "**Termination of Participation**." Benefits will also cease upon termination of the Plan. Your rights and privileges under a particular Benefit will cease for you or your eligible family member when you or your family member ceases to be eligible for the particular Benefit.

Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. For example, if any benefit under the Plan is erroneously paid or exceeds the amount payable to you then you may be responsible for refunding the overpayment to the Plan. Consult the Benefit documents for additional information.

Administrative Requirements and Timelines

As described in the Benefit documents, there may be other reasons that a claim for benefits is not paid or is not paid in full. For example, claims must generally be submitted for payment within a certain period of time, and failure to submit within that time period may result in the claim being denied. In this regard, please consult the Benefit documents.

CLAIM FILING AND REVIEW PROCEDURES

Claim Filing Procedures

The Plan Administrator has delegated its responsibilities for deciding claims under the Benefits to certain insurance companies who serve as the named fiduciaries (or "Claims Fiduciaries") for their respective Benefits. (See Appendix A for a complete list of the Claims Fiduciaries and their addresses.)

The Claims Fiduciaries maintain the full power and sole discretion to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance or other contract. To obtain benefits, the Participant must follow the claims procedures under the applicable Benefit documents. The applicable Claims Fiduciary will decide a participant's claim in accordance with its reasonable claims procedures, which will comply with ERISA and the regulations thereunder.

The claims procedures applicable to each Benefit are described in the applicable document, insurance certificate or contract, benefit summary, or other governing document for the Benefit. If the applicable Benefit document(s) do not contain claims procedures that comply with Department of Labor Regulations, then the following procedures will apply.

You may designate an authorized person to act on your behalf. Throughout these claims procedures, the word "you" refers to both you and your authorized representative. No person (including a treating health care professional) will be recognized as an authorized representative until you designate them, except that for urgent care claims under the claims procedures for group health claims, a health care professional with knowledge of your medical condition (e.g., the treating physician) will be recognized as your authorized representative unless you provide specific direction otherwise.

Claims Procedure Under This Plan

If a claim under the Plan is denied in whole or in part, the Claims Fiduciary will notify you or your beneficiary in writing of the denial within 90 days of receipt of the claim. (This period may be extended to 180 days under certain circumstances.) The notification will be in writing and will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim, and an explanation of the claims review procedure. Within 60 days after receipt of a notice of denial, you or your beneficiary may submit a written request for reconsideration of the application to the Claims Fiduciary.

You may review all pertinent documents related to an adverse determination and may request a review by the Claims Fiduciary of the decision denying the claim. Any request for a review must be filed in writing with the Claims Fiduciary within 60 days after you receive written notice of the claim decision. Your written request for review must contain all additional information that you want the Claims Fiduciary to consider, including written comments, documents, records, and other information relating to the claim. Any request for reconsideration should be accompanied by documents or records

in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing.

The Claims Fiduciary will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended to 120 days under certain circumstances.) Any denial of your appeal will be provided in writing and will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a statement that you are entitled to receive, free of charge, access to all documents, records, and other information relevant to your claim, and a statement of your right to bring a civil action under section 502(a) of ERISA with a description of the limitations period provided by the Plan, including the date on which the limitations period will expire.

Claims Procedure for Determination of Disability

The following claims procedure applies specifically to claims made under the Plan for benefits based on a determination of disability. The claims procedure contained in the Benefit documents will supersede this procedure so long as the claims procedure in the applicable Benefit document(s) comply with the Department of Labor Regulations.

If a claim under the Plan for a benefit based on a determination of disability is denied in whole or in part, you or your beneficiary will receive written notification no later than 45 days after the Claims Fiduciary's receipt of the claim. The Claims Fiduciary may extend this period for up to 30 additional days provided it determines that the extension is necessary due to matters beyond its control, and you are notified of (1) the extension before the end of the initial 45-day period and (2) the date by which the Claims Fiduciary expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Claims Fiduciary determines that, due to matters beyond its control, it cannot make the decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the Claims Fiduciary expects to render a decision.

The extension notice will explain the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, you must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information. The period from which you are notified of the additional required information to the date you respond is not counted as part of the determination period.

A notice that your claim has been denied will be in writing and will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based; a description of any additional information needed to process the claim and an explanation of the claims review procedure; and a discussion of the decision, including an explanation of the basis for disagreeing with or not following the views of health care professionals treating you and vocational professionals who evaluated you. The notice will also include a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim, as well as a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an

explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

You have 180 days to appeal an adverse benefit determination. You will be notified of the Claims Fiduciary's decision upon review within a reasonable period of time, but no later than 45 days after the Claims Fiduciary receives your appeal request. The 45-day period may be extended for an additional 45-day period if the Claims Fiduciary determines that special circumstances (such as the need to hold a hearing) require an extension of time. You will be provided with written notice prior to the expiration of the initial 45-day period. Such notice will state the special circumstances requiring the extension and the date by which the Claims Fiduciary expects to render a decision.

Before issuing an adverse determination on review, the Claims Fiduciary will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with the claim, as well as a description of any new or additional rationale on which the denial is based. This information will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

A notice that your appeal has been denied will be provided in writing and will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based; a discussion of the decision, including an explanation of the basis for disagreeing with or not following the views of health care professionals treating you and vocational professionals who evaluated you; and a statement of your right to bring a civil action under section 502(a) of ERISA with a description of the limitations period provided by the Plan, including the date on which the limitations period will expire. The notice will also include a statement that you are entitled to receive, free of charge, access to all documents, records, and other information relevant to your claim, as well as a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

Claims Procedure for Group Health Plans

The following claims procedures apply specifically to claims made under any group health plan under this Plan (that is, the Medical, Dental, Vision, Medical Flexible Spending Account, and Employee Assistance Program Benefits). The claims procedures contained in the Benefit documents will supersede this procedure so long as the claims procedure in the applicable Benefit booklet complies with the Department of Labor Regulations.

Benefit Determinations

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice from the Claims

Fiduciary within 30 days of receipt of the claim, so long as all needed information was provided with the claim. The Claims Fiduciary will notify you within the 30-day period if additional information is needed to process the claim and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims Fiduciary will notify you of a denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

Pre-Service Claims

Pre-Service Claims are those claims that require certification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Fiduciary within 15 days of receipt of the claim. If you filed a Pre-Service Claim improperly, the Claims Fiduciary will notify you of the improper filing and how to correct it within 5 days.

After reviewing the revised Pre-Service Claim, the Claims Fiduciary will notify you of any additional information needed within 15 days and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Fiduciary will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

Urgent Care Claims

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically as soon as possible, but not later than 72 hours after the Claims Fiduciary receives all necessary information, or such other timeframe as required under federal law, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.
- If you filed an Urgent Care Claim improperly, the Claims Fiduciary will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the Claims Fiduciary will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after the Claims Fiduciary's receipt of the requested information or the end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided as soon as possible, and the Claims Fiduciary will notify you of the determination within 24 hours after receipt of the claim, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Notice of Claim Decision

Notice of an adverse claim determination will be provided in writing in a culturally and linguistically appropriate manner and will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based; a description of any additional information needed to process the claim with an explanation of why the additional information is necessary; and an explanation of the claims review procedure. Upon request and free of charge, you will be provided a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

How to Appeal a Claim Decision

If you disagree with a claim determination you can contact the Claims Fiduciary in writing to formally request an appeal. Your appeal request must be submitted to the Claims Fiduciary within 180 days after you receive the claim denial.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Fiduciary may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

If your circumstance warrants an expedited appeals procedure, then you should contact the Claims Fiduciary immediately. You will be asked to explain, in writing, why you believe the claim should have been processed differently and to provide any additional material or information necessary to support the claim.

Pre-Service and Post-Service Claim Appeals

You will be provided with written or electronic notification of the decision on your appeal as follows:

- For appeals of Pre-Service Claims, the appeal will be conducted, and you will be notified by the Claims Fiduciary of the decision within 15 days from receipt of a request for appeal.
- For appeals of Post-Service Claims, the appeal will be conducted, and you will be notified by the Claims Fiduciary of the decision within 30 days from receipt of a request for appeal.
- For appeals of Concurrent Care Claims, the appeal will be conducted, and you will be notified by the Claims Fiduciary of the decision before treatment ends or is reduced, or within 24 hours from receipt of a request for appeal if the claim is a request for extension involving urgent care.

Urgent Care Claim Appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your doctor should call the Claims Fiduciary as soon as possible.
- The Claims Fiduciary will provide you with a written or electronic determination as soon as possible, but not later than 72 hours following receipt of your request for review of the determination.

<u>Notice of Adverse Decision on Appeal</u>

Every notice of an adverse determination on appeal will be provided in a culturally and linguistically appropriate manner and will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, and a description of the claims procedures for any additional level of appeal and the applicable time limits, external review rights, and a statement of your right to bring a civil action under Section 502(a) of ERISA after exhausting the Plan's claims procedures. The notice will also include a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim, as well as a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit. The notice will include the following statement: "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."

External Review

You may have the right to request an external review of a group health plan claim involving medical judgment, as determined by the external reviewer, or a coverage rescission. You must request the external review within four months of the date you receive an adverse benefit determination. If your request for an external review is determined eligible for such a review, an independent organization will review the Claims Fiduciary's decision and provide you with a written determination, as described in the Benefits documents.

The external review decision is binding on you and the Plans, except to the extent other remedies are available under federal law. The external review process does not apply to an adverse benefit determination or final internal adverse benefit determination that is not related to medical judgment or coverage rescission.

Exhaustion

If you do not exercise your appeal right within the timeframe set forth in the claims procedures described in the official plan document or summary plan description for the applicable Benefit policy, you may lose your right to file suit in a state or federal court.

Limitations Period

Unless stated otherwise in the official plan document or summary plan description for the applicable Benefit, any lawsuit on a claim for benefits under the Plan must be initiated within 12 months after the date of final disposition of the claim.

CONTINUATION COVERAGE

Different types of continuation coverage that may apply to particular Benefits, as highlighted below, including state laws that may provide continuation and conversion coverage.

Continuation Coverage Under COBRA

If coverage under a group health plan (for example, the Medical Benefit and Dental Benefit) for you or your eligible family member(s) ceases because of certain "qualifying events" specified in the Consolidation Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") (such as termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of dependent), then you and your eligible family member(s) may have the right to purchase continuation coverage for a temporary period of time.

The following sections explain COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become

eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law. COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Benefit documents or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this Section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Medical or Dental Benefit is lost because of the qualifying event. Generally, domestic partners will not become qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Medical or Dental Benefit because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Medical or Dental Benefit because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;

- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

Qualified beneficiaries will be offered COBRA continuation coverage only after the Plan Administrator has been notified that a qualifying event has occurred. The Employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: the Plan Administrator, University of New England, 11 Hills Beach Road, Biddeford, ME, 04005, 207-602-2394.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Employee Assistance Program (EAP) COBRA Coverage?

COBRA coverage under the EAP will be provided by automatic extension of your participation in the EAP at no cost and without the need for you to make a COBRA election. Coverage will continue under the EAP for the maximum period allowed under COBRA (18 or 36 months depending on the reason for your COBRA eligibility). Please contact the Plan Administrator with any questions regarding you COBRA rights under the EAP.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are

still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Information about the Plan and COBRA continuation coverage can be obtained from the Plan Administrator. Contract information for the Plan Administrator is contained in the "GENERAL INFORMATION" Section.

Continuation Coverage Under USERRA

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). More information about coverage available under USERRA is available from the Plan Administrator.

MISCELLANEOUS PROVISIONS

Plan Administrator

The administration of the Plan is under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator 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 administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that the delegation is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibility. The Plan Administrator has the discretionary authority to interpret the Plan to make eligibility and benefit determinations, and has the sole discretionary authority (unless such discretionary authority is expressly delegated to a Claims Fiduciary) to interpret and apply the terms of the Plan and component Benefit documents, to make eligibility and benefit determinations, and to make factual determinations as to whether any individual is entitled to receive any benefits under the applicable insurance or other contract.

The Claims Fiduciaries for each Benefit are responsible for (a) determining eligibility for a benefit and the amount of any benefits payable under the Plan; and (b) providing the claims procedures to be followed and the claims forms to be used by eligible individuals pursuant to the Plan. As Claims Fiduciaries, the insurance companies have the discretionary authority to interpret the Plan in order to make benefit determinations. They also have the authority to require eligible individuals to furnish them with information they determine necessary for the proper administration of the Plan.

The Employer will bear the incidental costs of administering the Plan.

Right of Recovery

Whenever the Plan Administrator has allowed benefits to be paid by the Plan which have been paid or should have been paid by any other plan, or which were erroneously paid, the Plan Administrator will have the right to recover any excess payments from the appropriate party.

Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for its own willful misconduct or willful breach of the Plan.

Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance carriers for the purposes of providing any Benefits under the Plan, and (b) to replace any insurance

carriers or contracts. Any monies refunded to the Employer, due to actuarial error in the rate calculation, will be the property of and retained by the Employer.

No Contract of Employment

No provision of the Plan is to be considered a contract of employment between you and the Employer. The Employer's rights with regard to disciplinary action and termination of any Employee, if necessary, are not changed by any provision of the Plan.

Amendment and Termination

The Employer reserves the right to amend or discontinue the Plan or any Benefits offered under the Plan for any reason. If the Plan is amended or terminated, it will not affect any benefit to which you were entitled before the date of the amendment or termination.

Amendment of Appendices

The Plan Administrator may periodically update Appendices A and B to the Plan to reflect the current listing of Benefits available under the Plan and the defined terms from the Employer's Personnel Handbook pertinent to the Plan. Any such updates shall not necessitate a formal amendment to this Plan document.

HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), requires, among other things, that group health plans protect the confidentiality and privacy of individually identifiable health information. The Benefits offered through the Plan and those administering the Benefits will use and disclose health information only as allowed by federal law. If a covered individual has a complaint, questions, concerns, or requires a copy of the HIPAA Privacy Notice, please contact the Plan Administrator.

Governing Law

The Plan shall be construed, administered, and enforced according to the laws of the State of Maine, to the extent not superseded by the Code, ERISA, or any other federal law.

No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer make any commitment or guarantee that any amounts paid to or for your benefit under the Plan will be excludable from your gross income for federal, state, or local income tax purposes. It is your obligation to determine whether each payment under the Plan is excludable from your gross income and to notify the Plan Administrator if you have any reason to believe that a payment under the Plan is not excludable.

Tax Consequences of Domestic Partner Benefits

Unless your domestic partner or your domestic partner's dependent children, if any, are considered your federal tax dependents under the Code for health benefit purposes, the Internal Revenue Service currently treats as imputed income to you the value of the coverage provided for your domestic partner and your domestic partner's dependent children, if any, less any contributions paid by you on an after-tax basis for this coverage. You are advised to consult with your tax advisor to determine if your domestic partner and your domestic partner's dependent children are your federal tax dependents and to review the tax consequences of electing domestic partner benefit coverage. If you and your domestic partner's tax status changes because, for example, you get married or your domestic partner begins to qualify as your tax dependent, you should notify the Plan Administrator as soon as possible.

Indemnification of Employer

If you receive one or more payments or reimbursements through the Plan on a tax-free basis that do not qualify for that treatment under the Code, you shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from any payments or reimbursements.

Non-Assignability of Rights

Except as otherwise explicitly set forth in the official plan document or summary plan description for the Benefits offered under the Plan, your benefits and rights under the Plan and the Benefits offered thereunder (including the right to request documents and bring a lawsuit under ERISA) are personal to you and cannot be transferred or assigned to any other person or entity. Nothing in the Plan shall be construed to make the Plan or Employer liable to any third party to whom an Eligible Employee (or his or her spouse, domestic partner, or dependents) may be liable for medical care, treatment, or services. Direct payments to a provider will not constitute a waiver of this non-assignability of rights provision under the Plan.

STATEMENT OF ERISA RIGHTS

The Plan and the Benefits offered under the Plan are governed by ERISA. As a participant in the Plan you are entitled to certain rights and protections under 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, including insurance contracts, 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, 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, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- Under certain circumstances, continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the documents governing the applicable Benefit policy on the rules governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries. In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "Fiduciaries" of the Plan, have a duty to do so prudently and in 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 the above rights. For instance, if you request a copy of Plan documents or the latest annual report (if any) 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 because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court within 12 months of the final disposition of your claim. In addition, if you disagree with the Plan Administrator's decision (or lack thereof) concerning the qualified status of a medical child support order, then 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 is frivolous. Service of legal process may be made upon the Plan Administrator.

Assistance With Your Questions. If you have any questions about the Plan or the Benefits, 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 visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

IN WITNESS WHEREOF, the Employer has adopted this University of New England Employee Benefit Plan, effective as of January 1, 2025.

University of New England

By: 

Title: Chief Human Resources Officer, Associate VP of HR

Date: 11/17/25

APPENDIX A

Effective January 1, 2026

BENEFITS

Refer to Appendix B for definitions of the capitalized terms in this Appendix A.

Medical	
Provider or Program Administrator Contact Information	Cigna 500 Southborough Dr. #302 South Portland ME 04106 1-866-494-2111 www.mycigna.com
Funding Medium	Fully Insured
Claims Fiduciary	Cigna
Eligibility and entry date	All full-time and half-time Employees in a regularly budgeted position, as described in the Employer's personnel handbook, and any Employee who is required to receive an offer of coverage pursuant to the Employer's ACA look-back measurement policy. First day of the calendar month coincident with or next following date of hire or change in status.
Retiree Medical	
Provider or Program Administrator Contact Information	Cigna 500 Southborough Dr. #302 South Portland ME 04106 1-866-494-2111 www.mycigna.com
Funding Medium	Fully Insured
Claims Fiduciary	Cigna

Eligibility and entry date	Any Employee who: (i) retires from the Employer at age 60 or older (ii) with at least 20 years of continuous service in a full-time or half-time regularly budgeted position, as described in the Employer's personnel handbook, (iii) is covered under the Employer's major medical plan immediately prior to retirement, and (iv) elects retiree medical coverage at the time of retirement. Retiree medical coverage terminates when the retiree becomes eligible for Medicare Part A, B, and D. Eligibility for retiree medical coverage for an otherwise eligible spouse terminates when the spouse becomes eligible for Medicare Part A, B, and D. Dependents will be eligible for retiree medical coverage so long as either the retiree or any eligible spouse remains enrolled in retiree medical coverage under the Plan. First day of the calendar month coincident with or next following the Employee's retirement.
Dental	
Provider or Program Administrator Contact Information	Delta Dental 1022 Portland Road, Suite 2 Saco, ME 04072 1-800-832-5700 www.nedelta.com
Funding Medium	Self-insured
Claims Fiduciary	Delta Dental
Eligibility and entry date	All full-time and half-time Employees in a regularly budgeted position, as described in the Employer's personnel handbook. First day of the calendar month coincident with or next following date of hire or change in status.

Vision	
Provider or Program Administrator Contact Information	Cigna 500 Southborough Dr. #302 South Portland ME 04106 1-866-494-2111 www.mycigna.com
Funding Medium	Fully Insured
Claims Fiduciary	Cigna
Eligibility and entry date	All full-time and half-time Employees in a regularly budgeted position, as described in the Employer's personnel handbook. First day of the calendar month coincident with or next following date of hire or change in status.
Medical Flexible Spending Account	
Provider or Program Administrator Contact Information	Sentinel Group 100 Quannapowitt Parkway Wakefield, MA 01880 1-888-762-6088 www.sentinelgroup.com
Funding Medium	Self-insured
Claims Fiduciary	Sentinel Group
Eligibility and entry date	All full-time and half-time Employees in a regularly budgeted position, as described in the Employer's personnel handbook. First day of the calendar month coincident with or next following date of hire or change in status.
Basic Life/AD&D	
Provider or Program Administrator Contact Information	The Standard 1100 SW Sixth Avenue Portland, OR 97204 1-800-628-8600 www.standard.com
Funding Medium	Fully Insured
Claims Fiduciary	The Standard

Eligibility and entry date	All full-time Employees in a regularly budgeted position, as described in the Employer's personnel handbook. First day of the calendar month coincident with or next following date of hire or change in status.
Supplemental Life	
Provider or Program Administrator Contact Information	The Standard 1100 SW Sixth Avenue Portland, OR 97204 1-800-628-8600 www.standard.com
Funding Medium	Fully Insured
Claims Fiduciary	The Standard
Eligibility and entry date	All full-time and half-time Employees in a regularly budgeted position, as described in the Employer's personnel handbook. First day of the calendar month coincident with or next following date of hire or change in status.
Short-Term Disability	
Provider or Program Administrator Contact Information	The Standard 1100 SW Sixth Avenue Portland, OR 97204 1-800-368-2859 www.standard.com
Funding Medium	Fully Insured
Claims Fiduciary	The Standard
Eligibility and entry date	All full-time and half-time Employees in a regularly budgeted position, as described in the Employer's personnel handbook, who meet all requirements for coverage under the applicable insurance policy. First day of the calendar month coincident with or next following date of hire or change in status.

Long-Term Disability	
Provider or Program Administrator Contact Information	The Standard 1100 SW Sixth Avenue Portland, OR 97204 1-800-368-1135 www.standard.com
Funding Medium	Fully Insured
Claims Fiduciary	The Standard
Eligibility and entry date	All full-time Employees in a regularly budgeted position, as described in the Employer's personnel handbook, who meet all requirements for coverage under the applicable insurance policy. First day of the calendar month coincident with or next following date of hire or change in status.
Employee Assistance Program (full-time employees)	
Provider or Program Administrator Contact Information	The Standard 1100 SW Sixth Avenue Portland, OR 97204 1-800-368-1135 www.standard.com
Funding Medium	Fully insured
Claims Fiduciary	The Standard
Eligibility and entry date	All Employees who are enrolled in the Employer's long-term disability benefit and their spouses, dependents, and children up to age 26. First day of the calendar month coincident with or next following date of hire or change in status.

APPENDIX B

Effective January 1, 2026

Defined Terms from UNE Personnel Handbook The following defined terms used in this document have the meaning set forth in the University of New England Personnel Handbook as set forth below:

EXEMPT/NON-EXEMPT STATUS - Human Resources determines a position's exempt/non-exempt status, following criteria established by the Fair Labor Standards Act and Maine Law. These criteria include:

- salary level;
- the duties and responsibilities assigned to the position;
- the level of supervision received;
- whether or not specialized training or education is required to perform the duties;
- if discretion and judgment must regularly be exercised as part of the duties; and
- the amount of time and effort spent performing various duties.

EXEMPT - Employees whose responsibilities and job functions are such that tests established by the Federal and State Laws exempt them from minimum wage and overtime pay requirements.

NON-EXEMPT - Employees whose responsibilities and job functions are such that tests by Federal and State Laws require that they be paid at least minimum wage and time and one-half of their regular rate of pay for any and all hours worked over forty in a week.

REGULAR FULL-TIME - Employees regularly working a minimum of 35 hours per week (non-exempt) or 40 hours per week (exempt) for at least nine months of the year in a position that is regularly budgeted as a full-time position.

REGULAR HALF-TIME - Employees regularly working a minimum of 20 hours per week but less than 35 (non-exempt) or a minimum of 20 hours but less than 40 hours per week (exempt) for at least nine months of the year and who hold a position that is budgeted as a half-time position.

TEMPORARY, ADJUNCT AND PART-TIME - Employees whose positions are budgeted at less than half-time (or not budgeted at all), and whose work hours are fewer than 20 hours per week, and/or whose work months are fewer than 9 per year.