

HAVERFORD COLLEGE
HEALTH & WELFARE PLAN
(As Amended and Restated Effective January 1, 2021)

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**HAVERFORD COLLEGE
HEALTH & WELFARE PLAN**

(As Amended and Restated Effective January 1, 2021)

This is the Haverford College Health & Welfare Plan, as amended and restated effective January 1, 2021 (the “Plan”), for the benefit of eligible employees of Haverford College and those of its affiliates that have adopted the Plan. The purpose of the Plan is to help provide certain welfare benefits for each participating Eligible Employee and his or her eligible Dependents. Accordingly, the Plan is intended to constitute an “employee welfare benefit plan” within the meaning of §3(1) of ERISA.

ARTICLE I. DEFINITIONS

The following words and phrases as used herein have the following meanings unless a different meaning is required by the context:

1.1. “Administrator” means the Director of Benefits Administration, or such other person(s) or entity appointed by the Sponsor to administer the Plan. In the event that the Director of Benefits Administration is no longer available to serve and no successor person(s) or entity is appointed by the Sponsor, then the Sponsor shall be the Administrator.

1.2. “Adverse Benefit Determination” means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Claimant’s eligibility to participate in the Plan or any Benefit Program, and including, with respect to a Benefit Program that is a Group Health Plan, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. An Adverse Benefit Determination also includes any Rescission of Coverage, including any rescission of disability coverage with respect to a Claimant (whether or not, in connection with the Rescission of Coverage, there is an adverse effect on any particular disability Benefit at that time).

1.3. “Aggregate Lifetime Limit” means, with respect to a Benefit Program that is a Group Health Plan, the dollar limitation on the total amount of Benefits to be paid under such Group Health Plan with respect to an individual or other coverage unit.

1.4. “Alternate Recipient” means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under a Group Health Plan with respect to such Participant. For purposes of the Benefits provided under a Benefit Program, an Alternate Recipient shall be treated as a Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

1.5. “Annual Limit” means, with respect to Benefits under a Benefit Program that is a Group Health Plan, a dollar limitation on the total amount of Benefits to be paid in a calendar year under such Group Health Plan with respect to an individual or other coverage unit. A Benefit Program that is a Group Health Plan, other than the Haverford College Health Flexible Spending Account, may not place an Annual Limit on Essential Health Benefits.

1.6. “Appeals Fiduciary” means the person, entity or organization responsible for reviewing appeals for an Adverse Benefit Determination and ultimately deciding whether an appeal is granted or denied. In the case of an appeal with respect to Group Health Plan Benefits or disability Benefits, the Appeals Fiduciary shall not be the same person as the Claims Fiduciary, nor in such cases may the Appeals Fiduciary be a subordinate of the Claims Fiduciary. The identity and address of the Appeals Fiduciary for a particular Benefit Program is set forth in the Applicable Contracts and Summary Plan Descriptions.

1.7. “Applicable Contracts” means the contracts, agreements, policies, terms sheets and other similar documents (excluding any collective bargaining agreement or Summary Plan Description) pursuant to which Benefits are provided under a Benefit Program. The terms of the Applicable Contracts, as in effect from time to time, are hereby incorporated into the Plan and each applicable Benefit Program. The Applicable Contracts are set forth on Appendix A which may be revised from time to time without a Plan amendment.

1.8. “Approved Clinical Trial” means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening condition and which is described in one of the following subsections:

1.8.1. Federally Funded Trials. The study or investigation is approved or funded by one or more of the following: (i) The National Institutes of Health, (ii) The Centers for Disease Control and Prevention, (iii) The Agency for Health Care Research and Quality, (iv) The Centers for Medicare & Medicaid Services, (v) a cooperative group or center of any of the aforementioned entities or the Department of Defense or the Department of Veterans Affairs, (vi) a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, (vii) The Department of Veterans Affairs, The Department of Defense, or The Department of Energy provided that the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines to: (a) be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and (b) assure unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

1.8.2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

1.8.3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

1.9. “Beneficiary” means a person (as defined in §3(9) of ERISA) designated by a Participant, or by the terms of the Plan, as the party entitled to Benefits hereunder.

1.10. “Benefit” means the amount payable to, or on behalf of, a Participant, Dependent or Beneficiary on account of coverage under any Benefit Program as specified from time to time in the Applicable Contracts and Summary Plan Descriptions.

1.11. “Benefit Program” means each of the various programs offering Benefits under the Plan as listed in Appendix A, which may be revised from time to time without a Plan amendment. The Health Reimbursement Account Program, which was previously offered under the Plan, was terminated effective December 31, 2019. The substantive terms of each Benefit Program are set forth in the Applicable Contracts and Summary Plan Descriptions, as in effect from time to time.

1.12. “Breach of Unsecured Protected Health Information” means the acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted under the Privacy Standards which compromises the security or privacy of the Protected Health Information. Except as provided below, an acquisition, access, use or disclosure of Protected Health Information in a manner not permitted under the Privacy Standards shall be presumed to be a “Breach” unless the Plan demonstrates that there is a low probability that the Protected Health Information has been compromised based on a Risk Assessment. The term “Breach” shall not include:

1.12.1. any unintentional acquisition, access, or use of Protected Health Information by a Plan Employee or person acting under the authority of the Plan, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the Privacy Standards; or

1.12.2. any inadvertent disclosure by a person who is authorized to access Protected Health Information on behalf of the Plan to another person authorized to access Protected Health Information of the Plan and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the Privacy Standards; or

1.12.3. a disclosure of Protected Health Information where the Plan has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

1.13. “Business Associate” means, with respect to a Benefit Program that is a Group Health Plan, a person other than a Group Health Plan Employee, who: (i) on behalf of the Plan or the Organized Health Care Arrangement in which the Plan participates, creates, receives, maintains, or transmits Protected Health Information for a function or activity regulated under the Privacy Standards or Security Standards, including claims processing or administration, utilization review, quality assurance, patient safety activities, billing, benefit management, practice management and repricing; or (ii) provides legal, actuarial, accounting, consulting, data

aggregation, management administrative, accreditation, or financial services to or for the Group Health Plan, or to or for the Organized Health Care Arrangement in which the Group Health Plan participates, where the provision of the service involves the disclosures of Protected Health Information from the Group Health Plan or the Organized Health Care Arrangement, or from another Business Associate of the Group Health Plan or the Organized Health Care Arrangement to the person.

1.14. “Cafeteria Plan” means the Haverford College Flexible Benefits Plan which includes the Haverford College Health Flexible Spending Account and the Haverford College Dependent Care Flexible Spending Account.

1.15. “CHIP Plan” means a state child health plan under the State Children’s Health Insurance Program established under title XXI of the Social Security Act.

1.16. “Claimant” means a Participant, Beneficiary or Dependent (and the authorized representative of any such person) claiming a Benefit under the Plan or under any Benefit Program.

1.17. “Claims Fiduciary” means the applicable insurance carrier or third-party administrator designated under the applicable Benefit Program as set forth in the Applicable Contracts and Summary Plan Descriptions.

1.18. “COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, and the temporary and final regulations issued thereunder, all as from time to time in effect, and any successor statutory or regulatory provision.

1.19. “Code” means the Internal Revenue Code of 1986, and the temporary and final regulations issued thereunder, all as from time to time in effect, and any successor statutory or regulatory provision.

1.20. “Dependent” means, unless otherwise stated in an Applicable Contract or Summary Plan Description, or in cases where a Benefit is provided through insurance and applicable state law mandates a more expansive definition of “Dependent,” an individual who is:

1.20.1. the Spouse of a Participant;

1.20.2. the Participant’s Domestic Partner; or

1.20.3. a child described under Sections 1.20.3.1 or 1.20.3.2:

1.20.3.1. a child, as defined under section 152(f)(1) of the Code, of the Participant or the Participant’s Domestic Partner who has not attained age 26; or

1.20.3.2. an unmarried child of the Participant or the Participant’s Domestic Partner who is disabled and incapable of self-sustaining employment because of

physical or mental disability, and is primarily dependent on the Participant for support. At the time of the child's initial disability, the child must have been considered a Dependent as set forth in this Section. For purposes of this sub-paragraph

1.20.3.2.1 "child" means a natural or adopted child of the Participant or Domestic Partner; a step-child of the Participant or Domestic Partner whose legal residence is with the Participant; a child for whom the Participant or Domestic Partner has been made legal guardian or given court-appointed custody and whose legal residence is with the Participant; or a child for whom the Participant has initiated legal adoption proceedings and whose legal residence is with the Participant.

1.20.3.2.2 a child is considered "primarily dependent" on the Participant only if the Participant, or the Participant's Spouse, is entitled to claim a personal exemption deduction for such Participant's taxable year pursuant to section 151(c) of the Code and such child relies on the Participant for the majority (50% or more) of his or her financial support.

If a husband and wife are both Eligible Employees: (i) neither husband nor wife may be covered under a Benefit Program that is a Group Health Plan as both a Dependent and a Participant; and (ii) coverage will not be duplicated under a Benefit Program that is a Group Health Plan for an eligible Dependent of both the husband and wife.

The Administrator may demand proof of the continued eligibility of a Dependent from time to time. Failure to provide such proof upon request shall result in the termination of coverage under the applicable Benefit Program with respect to such Dependent.

Notwithstanding the foregoing, the term "Dependent" shall not include the Domestic Partner of a Participant nor the children of such Domestic Partner of a Participant for purposes of any Benefit Program other than the Medical Program, Dental Program and Vision Program.

1.21. "Designated Record Set" means a group of records maintained by or for the Plan that: (i) includes medical records and billing records about individuals maintained by or for a covered health care provider; (ii) consist of enrollment, payment, claims adjudication, and case or medical management record systems; or (iii) used, in whole or in part, to make decisions about Participants and Beneficiaries. As used herein the term "record" means any item, collection, or grouping of information that includes Protected Health Information and is maintained, collected, used, or disseminated by or for the Plan.

1.22. "Domestic Partner" means an individual who, with respect to an unmarried Participant, satisfies the following criteria:

1.22.1. the individual and the Participant are jointly responsible for the basic living expenses and welfare of the other partner and can submit certain documentation as requested by the Administrator as proof of such financial interdependence;

1.22.2. the individual is not related to the Participant by adoption or blood, or other degree of closeness, which would prohibit legal marriage in the State or Commonwealth in which the partners reside;

1.22.3. the individual and the Participant are each at least 18 years of age;

1.22.4. the individual and the Participant are each the sole domestic partner of the other partner with whom they have a close committed relationship for the last six months;

1.22.5. the individual and the Participant satisfy or agree to satisfy the requirements of any applicable federal, state or local laws or ordinances relating to domestic partnerships;

1.22.6. neither the individual nor the Participant is married to any other individual, and, if previously married, a legal divorce or annulment has been obtained, or the former spouse is deceased;

1.22.7. neither the individual nor the Participant is a member of another domestic partnership, and if either previously was a member of a domestic partnership, that individual has taken the necessary legal, or other related steps to terminate such prior relationship;

1.22.8. the individual and the Participant have been living together on a continuous basis for at least six months prior to completing an affidavit of domestic partnership and can prove such cohabitation; and

1.22.9. the individual and the Participant execute an affidavit of domestic partnership in such form as may be required by the Administrator or provides such other evidence as the Administrator may require from time to time to demonstrate satisfaction of the other requirements of this Section.

An individual shall cease to be a Domestic Partner as of the date on which any of the above requirements is no longer satisfied. A Participant shall have no more than one Domestic Partner at any time for purposes of the Plan. In addition, a Participant shall notify the Administrator of any change in circumstance attested to in the affidavit of domestic partnership within 31 days of any such change in circumstance, in such form and manner as may be required by the Administrator.

1.23. “Effective Date” of this amended and restated Plan means January 1, 2021.

1.24. “Electronic Media” means: (i) electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as a magnetic tape or disk, optical disk, or digital memory card; or (ii) transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks,

and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

1.25. “Electronic Protected Health Information” or “Electronic PHI” means Protected Health Information that is transmitted by Electronic Media, or maintained in Electronic Media.

1.26. “Eligible Employee” means a common-law employee of a Participating Employer who is regularly scheduled to work a minimum of 30 hours per week, or such lesser amount as specified in a Participating Employer policy, and who has satisfied the service requirement and such other conditions, if any, specified in the Applicable Contracts and Summary Plan Descriptions. In addition, certain employees with variable work schedules may be eligible for a Group Health Plan only as specifically required under PPACA. Notwithstanding the foregoing, an employee who is a member of a unit whose terms and conditions of employment are subject to collective bargaining shall not be an Eligible Employee unless the applicable collective bargaining agreement provides for participation in the Plan. Leased employees (under §414(n) of the Code) and those individuals classified by a Participating Employer as an independent contractor, notwithstanding a contrary determination by any court or governmental agency, are not “Eligible Employees” under this Plan.

1.27. “Employer” means any other entity included with the Sponsor in a controlled group of corporations or trades or businesses within the meaning of §414(b) or §414(c) of the Code, or an affiliated service group within the meaning of §414(m) of the Code.

1.28. “ERISA” means the Employee Retirement Income Security Act of 1974, and the temporary and final regulations issued thereunder, all as from time to time in effect, and any successor statutory or regulatory provision.

1.29. “Essential Health Benefits” means “essential health benefits” under section 1302(b) of the PPACA which shall include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care and any other benefits as required under applicable regulations.

1.30. “Financial Requirement” includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an Aggregate Lifetime Limit and an Annual Limit.

1.31. “FMLA” means the Family and Medical Leave Act of 1993, and the temporary and final regulations issued thereunder, all as from time to time in effect, and any successor statutory or regulatory provision.

1.32. “Genetic Information” means, with respect to any individual: (i) information about the individual’s genetic tests; (ii) the genetic tests of family members of such individual; (iii) the manifestation of a disease or disorder in family members of such individual; or (iv) any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by the individual or any family member of the individual, but does not include information about the sex or age of an individual.

1.33. “Group Health Plan” means an “employee welfare benefit plan” within the meaning of Section 3(1) of ERISA that provides Medical Care.

1.34. “Health Care Professional” means a physician or other health care professional licensed, accredited or certified to perform specified health services consistent with applicable state law.

1.35. “Individually Identifiable Health Information” means health information, including Genetic Information or demographic information collected from an individual, and that: (i) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (ii) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual. The health information must also identify the individual, or provide a reasonable basis to believe the information can be used to identify the individual.

1.36. “Medicaid Plan” means a state plan for medical assistance approved under Title XIX of the Social Security Act.

1.37. “Medical Care” means amounts paid for: (i) the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; (ii) transportation primarily for and essential to the Medical Care referred to in clause (i); and (iii) insurance covering the Medical Care referred to in clauses (i) and (ii).

1.38. “Medical Child Support Order” means any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law that: (i) provides for child support with respect to a Participant’s child under a Group Health Plan or provides health benefit coverage pursuant to a state domestic relations law (including a community property law) and relates to benefits under such plan; or (ii) is made pursuant to a law relating to medical child support described in §1908 of the Social Security Act (the “Act”) with respect to a Group Health Plan.

1.39. “Medical or Surgical Benefits” means Benefits with respect to medical or surgical services, as defined under the applicable Benefit Program, but does not include Mental Health Benefits or Substance Use Disorder Benefits.

1.40. “Mental Health Benefits” means Benefits with respect to services for mental health conditions, as defined under the applicable Benefit Program, but does not include Substance Use Disorder Benefits.

1.41. “Organized Health Care Arrangement” means the Plan and the Cafeteria Plan, each of which may disclose Protected Health Information to the other for purposes of any health care operations or activities of such Organized Health Care Arrangement.

1.42. “Participant” means:

1.42.1. an Eligible Employee who participates in the Plan by satisfying the requirements of Section 2.2 and the applicable eligibility requirements of any Benefit Program; or

1.42.2. a former Eligible Employee who properly has elected to continue to participate in a Benefit Program that is subject to COBRA.

1.43. “Participating Employer” means the Sponsor and each Employer that has joined the Plan.

1.44. “PHS Act” means the Public Health Service Act and the temporary and final regulations issued thereunder, all as from time to time in effect, and any successor statutory or regulatory provision.

1.45. “Plan Year” means the 12-month period beginning each January 1 and ending the following December 31.

1.46. “Post-Service Claim” means any claim for a Benefit under a Benefit Program that is a Group Health Plan that is not a Pre-Service Claim.

1.47. “PPACA” means the Patient Protection and Affordable Care Act, and the temporary and final regulations issued thereunder, all as from time to time in effect, and any successor statutory or regulatory provision.

1.48. “Pre-Service Claim” means any claim for a Benefit under a Benefit Program that is a Group Health Plan with respect to which the terms of the Benefit Program condition receipt of the Benefit, in whole or in part, on approval of the Benefit in advance of obtaining Medical Care.

1.49. “Privacy Standards” shall mean the Standards for Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164, as amended from time to time.

1.50. “Protected Health Information” means, except as provided in 45 C.F.R. § 160.103, Individually Identifiable Health Information that is transmitted or maintained in Electronic Media or any other form or medium.

1.51. “Qualified Individual” means an individual who is a Participant or Dependent in a Group Health Plan who meets the following requirements:

1.51.1. the individual is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the treatment of cancer or other life-threatening disease or condition; and

1.51.2. either (a) the referring Health Care Professional is a participating health care provider and has concluded that the individual’s participation in such trial would be appropriate based upon the individual meeting the conditions described in Section 1.51.1; or (b) the individual provides medical and scientific information establishing that the individual’s participation in such trial would be appropriate based upon the individual meeting the conditions described in Section 1.51.1.

1.52. “Qualified Medical Child Support Order” or “QMCSO” is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Dependent is entitled under a group health plan. In order for such an order to be a QMCSO, it must specify: (i) the name and last known mailing address (if any) of the individual covered under the Plan and the name and mailing address of each such Alternate Recipient covered by the order; (ii) a reasonable description of the type of coverage to be provided to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and (3) the period of coverage to which the order pertains. However, such an order need not be recognized as “qualified” if it requires the provision of any type or form of benefit, or any option, not otherwise provided to Participants and Dependents without regard to this Section except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in §1908 of the Act.

1.53. “Rescission of Coverage” means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

1.54. “Restricted Employee” means any individual who qualifies as a “highly compensated individual” under section 105(h)(5) of the Code, “highly compensated participant” under section 125(e) of the Code or, to the extent applicable, a “highly compensated employee” under section 129(d) of the Code or a “key employee” under section 79(d) or section 125(b) of the Code.

1.55. “Risk Assessment” means an assessment performed by the Sponsor, a third party administrator or Business Associate, as applicable, of the risk that Protected Health Information has been compromised based on at least all of the following factors:

1.55.1. the nature and extent of the Protected Health Information involved, including the types of identifiers and the likelihood of re-identification;

1.55.2. the unauthorized person who used the Protected Health Information or to whom the disclosure was made;

1.55.3. whether the Protected Health Information was actually acquired or viewed; and

1.55.4. the extent to which the risk to the Protected Health Information has been mitigated.

1.56. “Routine Patient Costs” means all items and services consistent with the coverage provided in a Group Health Plan or coverage that is typically covered for a Qualified Individual who is not enrolled in an Approved Clinical Trial. Notwithstanding the foregoing, Routine Patient Costs do not include: (i) the investigational item, device, or service, itself; (ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

1.57. “Security Incident” means the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system as provided for in 45 C.F.R. § 164.304, as amended from time to time.

1.58. “Security Standards” mean the Security Standards for the Protection of Electronic Protected Health Information issued under the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164, as amended from time to time.

1.59. “Sponsor” means Haverford College and any other organization which succeeds it and elects to continue the Plan.

1.60. “Spouse” means a person who is legally married to a Participant under the laws of the state or nation in which the marriage was performed and such marriage has not been legally dissolved.

1.61. “Start Date” means the first day that an individual actively performs services as an Eligible Employee or the first day an individual again qualifies as an Eligible Employee following a termination of employment or other applicable event.

1.62. “Substance Use Disorder Benefits” means Benefits with respect to services for substance use disorders, as defined under the applicable Benefit Program.

1.63. “Summary Health Information” means information that may be Individually Identifiable Health Information, and: (i) that summarizes claims history, claims expenses, or type of claims experienced by individuals for whom the Sponsor has provided health benefits under a

Group Health Plan; and (ii) excludes the identifiers specified in 45 C.F.R. § 164.514(b)(2)(i) (except that geographic information described in § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code).

1.64. “Summary Plan Description” means a written description of one or more Benefit Programs provided to Participants and Beneficiaries pursuant to §104(b) of ERISA. The terms of each Summary Plan Description, as in effect from time to time, are hereby incorporated into the Plan. The Summary Plan Descriptions are set forth on Appendix C which may be revised from time to time without a Plan amendment.

1.65. “Treatment Limitation” includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

1.66. “Underwriting Purposes” means, with respect to a Group Health Plan or health insurance coverage offered in connection with a Group Health Plan:

1.66.1. rules for, or determination of, eligibility (including enrollment and continued eligibility) for Benefits under the Group Health Plan;

1.66.2. the computation of premium or contribution amounts under the Group Health Plan;

1.66.3. the application of any pre-existing condition exclusion under the Group Health Plan; and

1.66.4. other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

1.67. “Urgent Care Claim” means any claim under a Benefit Program that is a Group Health Plan for Medical Care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

1.67.1. could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or

1.67.2. in the opinion of a physician with knowledge of the Claimant’s medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is an Urgent Care Claim is to be determined by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Notwithstanding the preceding sentence, any claim that a physician with knowledge of the Claimant’s medical condition determines is an Urgent Care Claim shall be treated as an Urgent Care Claim.

ARTICLE II. PARTICIPATION

2.1. Commencement of Participation in the Plan. Participation in the Plan permits an Eligible Employee (and, if applicable, his or her Dependents) to be eligible to receive Benefits under one or more of the Benefit Programs. An Eligible Employee (and, if applicable, a Dependent) is eligible to receive Benefits under a Benefit Program, however, only if he or she has satisfied the eligibility conditions applicable to that Benefit Program and has properly enrolled in such Benefit Program in accordance with procedures established by the Administrator. In addition, in accordance with uniform and non-discriminatory procedures established by the Administrator, the Administrator may, from time to time, require additional information or documentation confirming the employment status of a Participant's Spouse or Domestic Partner and level of benefits under a comparable benefit program, if any, received by such Spouse or Domestic Partner in connection with his or her employment or confirming an individual's status as a Dependent (such as a birth certificate, proof of legal guardianship, or disability).

2.2. Commencement of Participation for Eligible Employees. In accordance with Section 2.1, each Eligible Employee will become a Participant under a Benefit Program as of the later of:

2.2.1. for an individual who becomes an Eligible Employee during a Plan Year, his or her Start Date; provided (i) the Eligible Employee elects coverage under the Benefit Program as of his Start Date, or (ii) coverage is automatically provided as of his or her Start Date under the terms of the Benefit Program; or

2.2.2. the first day as of which an Eligible Employee is covered under the Benefit Program as set forth in the Applicable Contracts and Summary Plan Descriptions.

2.2.3. Commencement of Participation After Rehire or Change in Eligible Status. Except as provided in an applicable Summary Plan Description, a Participant who terminates employment with the Participating Employer or who is no longer an Eligible Employee but who returns to employment (or eligible status) with a Participating Employer as an Eligible Employee within 30 days shall immediately be eligible to participate in the Plan upon his reemployment or change in eligible status.

2.3. Commencement of Participation for Dependents. In accordance with Section 2.1 and subject to Section 2.3.3 below, each eligible Dependent shall become covered under a Benefit Program as of the later of:

2.3.1. for an individual who becomes a Dependent during a Plan Year, the date the individual becomes a Dependent; provided (i) the Participant elects to cover the individual as a Dependent under the Benefit Program within 30 days of that date, or (ii) coverage is automatically provided as of such date under the terms of the Benefit Program; or

2.3.2. as of the earlier of (i) the first day of the Plan Year for which the Participant elects coverage for a Dependent under the Benefit Program pursuant to the benefit election procedure established by the Administrator, or (ii) the first day as of which such Dependent is covered under the Benefit Program as set forth in the Applicable Contracts and Summary Plan Descriptions.

2.3.3. In the event that a Participant's Spouse is employed by a Participating Employer or otherwise, the availability of coverage for the Participant's Dependents under this Plan shall be as set forth in the Applicable Contracts and Summary Plan Descriptions.

2.4. Special Enrollment Upon Loss of Coverage. A Benefit Program that is a Group Health Plan shall permit an Eligible Employee, who has satisfied the participation requirements but not enrolled for coverage (or a Dependent of such an Eligible Employee, who is eligible but not enrolled for coverage) to enroll for coverage under the terms of such Benefit Program if each of the following conditions is met:

2.4.1. the Eligible Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the individual;

2.4.2. the Eligible Employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the Sponsor required such a statement at such time and provided the Eligible Employee with notice of such requirement (and the consequences of such requirement) at such time;

2.4.3. the Eligible Employee's or Dependent's coverage described in Section 2.4.1;

2.4.3.1. was under COBRA and the coverage was exhausted; or

2.4.3.2. was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated;

2.4.4. under the terms of the Benefit Program, the Eligible Employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in Section 2.4.3.1 or termination of coverage or employer contributions described in Section 2.4.3.2.

2.5. Special Enrollment for Dependents.

2.5.1. A Benefit Program that is a Group Health Plan shall provide a special enrollment period as described in Section 2.5.2 during which a person (or, if not otherwise

enrolled, an Eligible Employee) may be enrolled under the Benefit Program as a Dependent, and in the case of the birth or adoption of a child, the Spouse of the Eligible Employee may be enrolled as a Dependent of the Eligible Employee if such Spouse is otherwise eligible for coverage, if each of the following conditions is met:

2.5.1.1. the Benefit Program makes coverage available with respect to a Dependent;

2.5.1.2. the Eligible Employee is participating under the Benefit Program (or has met any waiting period applicable to becoming a Participant under the Benefit Program and is eligible to be enrolled under the Benefit Program but for a failure to enroll during a previous enrollment period); and

2.5.1.3. such person becomes a Dependent of the Eligible Employee through marriage, birth or adoption or placement for adoption.

2.5.2. The special enrollment period required under Section 2.5.1 shall be for a period of 30 days and shall begin on the later of:

2.5.2.1. the date Dependent coverage is made available;

2.5.2.2. the date of the marriage, birth, adoption or placement for adoption (as the case may be).

2.5.3. If an Eligible Employee seeks coverage of a Dependent during the special enrollment period described in Section 2.5.2, the coverage of the Dependent shall become effective:

2.5.3.1. in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

2.5.3.2. in the case of a Dependent's birth, as of the date of such birth;
or

2.5.3.3. in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

2.6. FMLA Coverage.

2.6.1. Any Participant on FMLA leave together with the Participant's eligible Dependents shall, at the option of the Participant and in accordance with the terms of the Cafeteria Plan, continue to be covered under the Plan while the Participant is absent from work on an FMLA leave as if there were no interruption of active employment until the earlier of the expiration of such leave or the date the Participant gives notice to the Employer that the Participant does not intend to return to work at the end of the FMLA leave. Alternatively, for the

period of an FMLA leave, such a Participant may revoke his or her election to participate under any Benefit Program offered under the Plan in accordance with the terms of the Cafeteria Plan. If coverage is maintained during the leave, the Participant must continue to make any required contributions, as provided in Article IV below.

2.6.2. If a Participant chooses not to participate in the Plan (or any applicable Benefit Program) while on an FMLA leave, but subsequently returns to active working status on or before the expiration of the leave, the Participant and all eligible Dependents shall be entitled to be reinstated under the Plan (and each applicable Benefit Program) effective as of the date the Participant returns from FMLA leave, on the same terms as prior to taking the leave without any qualifying period, physical examination or exclusion of preexisting conditions.

2.6.3. Any Plan changes (e.g., in coverage, premiums or deductibles) which apply to all Participants shall also apply to a Participant on FMLA leave.

2.7. Cessation of Participation. Except as provided in Section 2.8 with respect to COBRA continuation coverage, a Participant and Dependent shall cease to participate in the Plan or a Benefit Program (as applicable) on the earliest of:

2.7.1. the date the Participant ceases to be employed by the Participating Employer (unless a later date is specified in the Applicable Contract, Summary Plan Description or any written agreement under which the Participating Employer agrees to extend participation under the Plan) and provided the Participant is not eligible for post-employment benefits;

2.7.2. the date the Participant ceases to satisfy the eligibility requirements of the Plan or a Benefit Program (as applicable) as specified in the Applicable Contract or Summary Plan Description;

2.7.3. the date on which the Plan or Benefit Program is terminated; or

2.7.4. the date the employer of the Participant ceases to be a Participating Employer in the Plan or Benefit Program unless the Applicable Contracts or Summary Plan Descriptions provide for termination of participation as of a subsequent date.

2.8. Continuation Coverage. Notwithstanding the foregoing, an eligible Participant or Dependent may elect to continue coverage under a Benefit Program that is a Group Health Plan in accordance with COBRA.

2.9. Uniformed Service. A Participant who is absent from employment with the Participating Employer on account of being in "uniformed service," as that term is defined under the Uniformed Services Employment and Re-employment Rights Act of 1994 ("USERRA"), may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Participant fails to apply for reinstatement or to return to employment with the Participating Employer. The Participant shall be responsible for making the required contributions during the period during which he or she is in "uniformed service" in accordance

with the manner prescribed by the Administrator. A Participant whose coverage under the Plan is terminated on account of his or her being in “uniformed service,” and is later reinstated within the relevant time period allowed by USERRA, shall not be subject to a new exclusion or waiting period requirement imposed by the Plan provided that such requirements would not have been imposed if coverage had not been terminated as a result of the “uniformed service.”

2.10. Qualified Medical Child Support Orders.

2.10.1. With respect to a Benefit Program that is a Group Health Plan, the Administrator shall cause an Alternate Recipient who is the subject of a QMCSO, to be covered by such Benefit Program in accordance with such QMCSO.

2.10.2. Upon receiving a Medical Child Support Order, the Administrator shall: (1) promptly notify the Participant and each Alternate Recipient covered by the order (at the address included in the order) in writing of the receipt of such order and the procedures for determining whether the order qualifies as a QMCSO, and (2) within a reasonable period after receipt of such order, make a determination as to whether or not the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination. To give effect to this requirement, the Administrator shall (1) establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order, and (2) permit any Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to the order.

2.10.3. The Administrator may modify a Participant’s coverage under a Benefit Program, without the Participant’s consent, in order to provide coverage to the Participant’s child(ren) pursuant to a QMCSO.

2.11. Special Enrollment Under the Children’s Health Insurance Program Reauthorization Act of 2009. This Section shall be construed in accordance with section 701(f) of ERISA. A Benefit Program that is a Group Health Plan shall permit an eligible Employee, who has satisfied the participation requirements but who has not enrolled for coverage (or a Dependent of such an Eligible Employee, who is eligible but not enrolled for coverage) to enroll for coverage under the terms of such Benefit Program if either of the following conditions is met:

2.11.1. Termination of Medicaid or CHIP Coverage. The Eligible Employee or Dependent is covered under a Medicaid Plan or under a CHIP Plan and coverage of the Eligible Employee or Dependent under such Medicaid Plan or CHIP Plan is terminated as a result of loss of eligibility for such coverage and the Eligible Employee requests coverage under the Benefit Program not later than 60 days after the date of termination of such coverage.

2.11.2. Eligibility for Premium Assistance under Medicaid or CHIP. The Eligible Employee or Dependent becomes eligible for premium assistance under Medicaid or CHIP with respect to a Benefit Program that is a Group Health Plan (including under any waiver or demonstration project conducted under or in relation to such a plan) and the Eligible

Employee requests coverage under the Benefit Program not later than 60 days after the date the Eligible Employee or Dependent is determined to be eligible for such assistance.

2.12. Conversion Privileges. If a Participant's coverage under any Benefit Program which provides group life insurance or group long-term disability insurance ceases for any of the reasons described in this Article, then the Participant may, if permitted under the Applicable Contract, convert his or her group life or group long-term disability insurance policy coverage to an individual policy.

2.13. Prohibition on Preexisting Conditions. Each Benefit Program that is a Group Health Plan shall not exclude any individual due to a preexisting condition.

ARTICLE III. BENEFITS

3.1. Benefits. The Plan is comprised of the Benefit Programs indicated on Appendix A. To qualify for Benefits under a Benefit Program, an Eligible Employee or Dependent must meet the eligibility requirements applicable to that specific Benefit Program. The Benefits payable under each Benefit Program, and the eligibility therefor, are set forth in the Applicable Contracts and the Summary Plan Descriptions, as in effect from time to time. The Plan shall not provide any Benefits attributable to claims that arise after an individual ceases to be a Participant or Dependent.

3.2. Minimum Hospital Stay for Newborns and Mothers. This Section shall be construed in accordance with section 711 of ERISA.

3.2.1. Except as provided in Section 3.2.2 and Section 3.2.3, a Benefit Program that is a Group Health Plan may not:

3.2.1.1. restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours;

3.2.1.2. restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a cesarean section, to less than 96 hours; or

3.2.1.3. require that a provider obtain authorization from the Plan for prescribing any length of stay required under Section 3.2.1.1 or Section 3.2.1.2.

3.2.2. Sections 3.2.1.1 and 3.2.1.2 shall not apply in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay otherwise required under such Sections is made by an attending provider in consultation with the mother.

3.2.3. This Section shall not apply to any Group Health Plan which does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

3.3. Mental Health and Substance Use Disorder Benefits. This Section shall be construed in accordance with section 712 of ERISA and section 9812 of the Code.

3.3.1. Aggregate Lifetime Limits. In the case of a Benefit Program that is a Group Health Plan that provides Medical and Surgical Benefits and either or both of Mental Health Benefits and Substance Use Disorder Benefits:

3.3.1.1. if the Benefit Program does not include an Aggregate Lifetime Limit on substantially all Medical and Surgical Benefits, the Benefit Program may not impose an Aggregate Lifetime Limit on Mental Health Benefits or Substance Use Disorder Benefits;

3.3.1.2. if the Benefit Program includes an Aggregate Lifetime Limit on substantially all Medical and Surgical Benefits (the “Applicable Lifetime Limit”), the Benefit Program shall either:

(i) apply the Applicable Lifetime Limit both to the Medical and Surgical Benefits to which it otherwise would apply and to Mental Health Benefits and Substance Use Disorder Benefits and not distinguish in the application of such limit between such Medical and Surgical Benefits and Mental Health Benefits or Substance Use Disorder Benefits; or

(ii) not include any Aggregate Lifetime Limit on Mental Health Benefits or Substance Use Disorder Benefits that is less than the Applicable Lifetime Limit.

3.3.2. Annual Limits. In the case of a Benefit Program that is a Group Health Plan that provides Medical and Surgical Benefits and either or both of Mental Health Benefits and Substance Use Disorder Benefits:

3.3.2.1. if the Benefit Program does not include an Annual Limit on substantially all Medical and Surgical Benefits, the Benefit Program may not impose an Annual Limit on Mental Health Benefits or Substance Use Disorder Benefits;

3.3.2.2. if the Benefit Program includes an Annual Limit on substantially all Medical and Surgical Benefits (the “Applicable Annual Limit”), the Benefit Program shall either:

(i) apply the Applicable Annual Limit both to Medical and Surgical Benefits to which it otherwise would apply and to Mental Health Benefits and Substance Use Disorder Benefits and not distinguish in the application of such limit between

Medical and Surgical Benefits and Mental Health Benefits or Substance Use Disorder Benefits;
or

(ii) not include any Annual Limit on Mental Health Benefits or Substance Use Disorder Benefits that is less than the Applicable Annual Limit.

3.3.3. Financial Requirements and Treatment Limitations. In the case of a Benefit Program that is a Group Health Plan that provides Medical and Surgical Benefits and either or both of Mental Health Benefits and Substance Use Disorder Benefits:

3.3.3.1. the Financial Requirements applicable to such Mental Health Benefits and Substance Use Disorder Benefits shall be no more restrictive than the predominant Financial Requirements applied to substantially all Medical and Surgical Benefits covered by the Benefit Program, and there shall be no separate cost sharing requirements that are applicable only with respect to Mental Health Benefits or Substance Use Disorder Benefits;

3.3.3.2. the Treatment Limitations applicable to such Mental Health Benefits and Substance Use Disorder Benefits shall be no more restrictive than the predominant Treatment Limitations applied to substantially all Medical and Surgical Benefits covered by the Benefit Program and there shall be no separate Treatment Limitations that are applicable only with respect to Mental Health Benefits or Substance Use Disorder Benefits.

3.3.3.3. A Financial Requirement or Treatment Limitation is considered to be “predominant” if it is the most common or frequent of such type of requirement or limitation.

3.3.4. Availability of Benefit Program Information. The criteria for medical necessity determinations made under a Benefit Program that is a Group Health Plan and which provides Mental Health Benefits or Substance Use Disorder Benefits shall be made available by the Administrator, in accordance with applicable regulations, to any current or potential Participant, Beneficiary or contracting provider upon request. In addition, the reason for any denial under a Benefit Program that is a Group Health Plan of reimbursement of payment for services with respect to Mental Health Benefits or Substance Use Disorder Benefits shall, on request or as otherwise required, be made available by the Administrator to the Participant or Beneficiary in accordance with applicable regulations.

3.3.5. Out-of-Network Providers. If the Benefit Program provides coverage for Medical and Surgical Benefits by out-of-network providers, the Benefit Program shall provide coverage for Mental Health Benefits and Substance Use Disorder Benefits (to the extent provided under such Benefit Program) by out-of-network providers in a manner that is consistent with the requirements of this Section.

3.3.6. Cost Exemption. This Section shall not (i) require any Group Health Plan to provide Mental Health Benefits or Substance Use Disorder Benefits; or (ii) apply to a

Group Health Plan if the application of this Section results in an increase in the cost under such Group Health Plan of at least one percent for any Plan Year.

3.4. Reconstructive Surgery. This Section shall be construed in accordance with section 713 of ERISA.

3.4.1. A Benefit Program that is a Group Health Plan that provides Medical and Surgical Benefits with respect to a mastectomy shall provide, in the case of a Participant or Dependent who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

3.4.1.1. reconstruction of the breast on which the mastectomy has been performed;

3.4.1.2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3.4.1.3. prosthesis and physical complications at all stages of the mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient.

3.5. Coordination of Plan Benefits with Additional Coverage.

3.5.1. If an individual covered under this Plan has Additional Coverage, as defined below, this Plan will coordinate the payment of benefits with an individual's Additional Coverage as follows:

3.5.1.1. if the Additional Coverage is automobile coverage (including no-fault automobile coverage) or does not have coordination of benefits provisions, the Plan's coverage shall be secondary;

3.5.1.2. if the Additional Coverage does have coordination of benefits provisions, the Additional Coverage that is applicable to the individual as an employee, rather than as a dependent, shall be primary;

3.5.1.3. if a Participant's Dependent child has Additional Coverage through such Participant's Spouse, the Plan's coverage of such Dependent shall be secondary unless the Participant's birthday falls earlier in the calendar year than the Spouse's birthday;

3.5.1.4. if a Participant's Dependent child has Additional Coverage through the Participant's former Spouse (whether separated or divorced), the Plan's coverage shall be secondary unless the Participant has custody of the child or has been assigned financial responsibility for the child's health care under a court-ordered support agreement or a QMCSO;

3.5.1.5. if none of the rules described in Sections 3.5.1.1 through 3.5.1.4 above apply, the Plan or Additional Coverage that has covered the individual incurring charges the longest shall be primary.

3.5.1.6. Notwithstanding the foregoing, the Plan will not pay expenses for a Participant's Dependent who has Additional Coverage under another Group Health Plan which is the primary coverage (the "primary plan"), if that primary plan denies benefits for a member's failure to (i) comply with a particular system of procedures, (ii) use only particular facilities or providers or care, or (iii) use the primary plan's highest benefit option. In addition, expenses which are rejected or reduced by the Dependent's primary plan as a result of the Dependent's failure to meet the requirements of that primary plan will not be paid by the Plan.

3.5.2. The term "Additional Coverage" means insurance or other coverage providing benefits or services for an individual's injury or illness, including any medical or dental benefit, including but not limited to:

3.5.2.1. group insurance or any other arrangement for coverage for individuals in a group, whether on an insured or self-insured basis;

3.5.2.2. any prepayment coverage, including health maintenance organizations ("HMOs"), Medicare, or Medicaid; and

3.5.2.3. homeowner, motorcycle and automobile coverages. In states with compulsory no-fault automobile insurance laws, each individual shall be deemed to have full no-fault coverage to the maximum extent available in that state.

3.5.3. Special Rule Regarding Coordination with Medicare and Medicaid.

3.5.3.1. Payment of Benefits to or on behalf of a Participant or Dependent under the Plan shall be made in accordance with any assignment of rights made by or on behalf of such Participant or Dependent as required by a Medicaid Plan.

3.5.3.2. With respect to an actively employed Eligible Employee, the fact that such an individual is eligible for or provided medical assistance under a Medicaid Plan shall not be taken into account in enrolling such individual as a Participant or in determining or making any payments for Benefits of an individual as a Participant or Dependent. With respect to a former Eligible Employee, however, the fact that such an individual is provided medical assistance under a Medicaid Plan shall be taken into account in determining or making any payments for benefits as a Participant.

3.5.3.3. To the extent that payment has been made under a Medicaid Plan where this Plan has a legal liability to make payment for items or service constituting such medical assistance; payment for Benefits under this Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to such a Participant for such payment for items or services.

3.5.3.4. If a Participant or Dependent becomes eligible for coverage under Title XVIII of the Social Security Act (“Medicare”), such Participant or Dependent may enroll in Medicare and continue to participate in the Plan. In such case, the Plan will provide primary coverage and Medicare will provide secondary coverage.

3.5.3.5. If a Participant or Dependent is covered under the Plan pursuant to a COBRA election and is also enrolled in Medicare after attaining age 65 or due to a disability (other than end stage renal disease), Medicare will provide primary coverage and the Plan will provide secondary coverage. However, if such Participant or Dependent has end stage renal disease the Plan will provide primary coverage and Medicare will provide secondary coverage.

3.6. Genetic Nondiscrimination. This Section shall be construed in accordance with sections 702 and 733(d) of ERISA. A Benefit Program that is a Group Health Plan shall not:

3.6.1. adjust any premium or contribution amounts on the basis of Genetic Information;

3.6.2. request or require that an Employee or an Employee’s family member undergo a genetic test; or

3.6.3. request, require or purchase Genetic Information for Underwriting Purposes.

3.7. Nondiscrimination. To the extent Benefits are provided under any part of the Plan that is subject to §79, §105(h), §125 or §129 of the Code, such Benefits shall not discriminate in favor of Restricted Employees or Participants, as required by ERISA or the Code. The Administrator may limit or deny any Benefit to the extent necessary to avoid any such discrimination. In addition, to the extent Benefits are provided under a Group Health Plan, such Benefits shall not discriminate against any Participant or Dependent on the basis of Genetic Information in accordance with the provisions of the Genetic Information Act of 2008, as amended.

3.8. Prohibition on Lifetime and Annual Limits. Pursuant to PPACA and the regulations issued thereunder a Benefit Program that is a Group Health Plan, other than the Haverford College Health Care Flexible Benefits Program, may not impose any Aggregate Lifetime Limit or Annual Limit on the dollar value of Essential Health Benefits.

3.8.1. Permissible Limits and Exclusions.

3.8.1.1. A Group Health Plan may exclude all Benefits for a specific condition.

3.8.1.2. A Group Health Plan may establish Aggregate Lifetime Limits or Annual Limits with respect to specific benefits that are not Essential Health Benefits provided such limits are otherwise permitted under applicable law.

3.9. Rescission of Coverage. No Benefit Program that is a Group Health Plan shall cause an individual to incur a Rescission of Coverage; except, in the event that an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact. A Group Health Plan must provide 30 days advance written notice of a Rescission of Coverage.

3.10. Additional Health Care Reform Benefits. Pursuant to PPACA, the following Benefits shall be offered under any Benefit Program that is a Group Health Plan:

3.10.1. Preventive Services. A Group Health Plan will provide “recommended preventive services,” as described in the applicable regulations, with no cost-sharing requirements (e.g., no deductibles, coinsurance or copayments). Recommended preventive services include: (i) evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Tax Force with respect to the individual involved; (ii) immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; (iii) with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and (iv) with respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by the Health Resources and Services Administration (not otherwise addressed by the recommendations of the United States Preventive Services Task Force).

3.10.2. Patient Protections.

3.10.2.1. Choice of Health Care Professional. If a Group Health Plan requires a Participant to designate a participating primary care provider, pediatrician, obstetrician or gynecologist, the Group Health Plan will provide notice to the Participant that the Participant may designate any participating primary care provider, pediatrician, obstetrician or gynecologist who is available to accept the Participant.

3.10.2.2. Emergency Services. Emergency services available under a Group Health Plan, in- or out-of-network, shall be provided without the Participant having to obtain prior authorization. In addition, emergency services will be provided without regard to any other term or condition of the Group Health Plan other than the (1) exclusion or coordination of benefits, (2) an affiliation or waiting period, or (3) applicable cost-sharing requirements. Administrative requirements or limitations will be no greater on out-of-network services than in-network services and cost-sharing requirements (e.g., copayments, deductibles and coinsurance rates) for out-of-network services will not exceed those for in-network services.

3.10.3. Approved Clinical Trials. Pursuant to Section 2709 of the PHS Act, if a Group Health Plan provides coverage to a Qualified Individual, then such Group Health Plan may not: (i) deny a Qualified Individual participation in an Approved Clinical Trial, (ii) deny, limit or impose additional conditions on the coverage of Routine Patient Costs for items and

services furnished in connection with participation in an Approved Clinical Trial; and (iii) may not discriminate against the Qualified Individual on the basis of the individual's participation in such Approved Clinical Trial.

ARTICLE IV. PLAN FUNDING

4.1. Plan Cost. The cost of each Benefit Program shall be paid by the Participating Employers and the Participants, in such proportion as the Sponsor (subject to collective bargaining, where applicable) shall determine from time to time.

4.2. Participating Employer Contributions. Participating Employer contributions shall be paid from the Participating Employers' general assets or from any other funding medium established by the Participating Employers (including a voluntary employees' beneficiary association established pursuant to §501(c)(9) of the Code).

4.3. Participant Contributions. Each Participant may be required to contribute to the Plan in an amount established by the Sponsor (subject to collective bargaining, where applicable) from time to time for the type of Plan coverage selected by such Participant. In addition, the rate of Participant contribution may depend upon the employment status and compensation of the Participant as established by the Sponsor. Each such Participant periodically shall complete an election form authorizing such contributions in accordance with procedures established by the Administrator. Participant contributions may be collected by the applicable Participating Employer by means of payroll deductions or such other method as may be determined by the Participating Employer, including, but not limited to payments pursuant to the Cafeteria Plan.

4.4. FMLA Leave.

4.4.1. Participating Employer Contributions.

4.4.1.1. While a Participant is on an FMLA leave, the Participating Employer shall continue to make the same contributions to this Plan on behalf of the Participant and his or her covered Dependents that it would have made had the Participant not taken such leave of absence.

4.4.1.2. The Participating Employer shall have the right to be reimbursed by the Participant for any and all premiums the Participating Employer has paid on behalf of the Participant and the Participant's covered Dependents with respect to a Benefit Program, that is a Group Health Plan, during a period of unpaid FMLA leave, if the Participant fails to return to employment at the expiration or exhaustion of such leave, unless the reason the Participant does not return is due to (i) the continuation, recurrence, or onset of a serious health condition of the Participant or the Participant's family member that would entitle the Participant to a FMLA leave; or (ii) other circumstances beyond the Participant's control. In the event that such Group Health Plan is self-insured, the amount the Participating Employer may recover is limited to the Participating Employer's share of allocable premium as would be calculated under COBRA, excluding the two percent fee for administrative cost. In this regard, the Participating

Employer shall have the right to obtain reimbursement from any funds that the Participating Employer might otherwise owe the Participant following the Participant's failure to return to employment, including (but not limited to) (i) any regular or overtime wages, commissions, salary, or bonuses; (ii) accrued vacation pay or sick leave pay; or (iii) benefits payable under this Plan or any other employee benefit plan under which the Participant is otherwise entitled to payment. In addition, the Participating Employer shall have the right to pursue reimbursement in a court of law. However, in pursuing reimbursement, the Participating Employer shall not resort to any method that violates any state or federal wage payment or other law.

4.4.1.3. Regardless of whether or not the Participant returns from a FMLA leave, the Participating Employer shall be entitled to recover from the Participant any required employee contributions the Participating Employer has made with respect to any Benefit Program on behalf of the Participant and his or her Dependents during an unpaid FMLA leave to ensure continuity of coverage (as provided under Section 4.4.2).

4.4.2. Participant Contributions. As soon as administratively feasible after a Participant qualifies for an FMLA leave, the Administrator shall give the Participant the opportunity to choose in writing between continued coverage during the leave of absence, or of suspending coverage for the leave's duration. If the Participant chooses ongoing coverage, the Participant must continue to make the same premium payments or contributions that he or she was making immediately before the leave took effect. The written election form given to the Participant must reflect that if the Participant elects to continue active participation, he or she will be able to make these payments in any combination of the following methods at his or her option:

4.4.2.1. Advance withholding from the Participant's last paycheck before any unpaid FMLA leave takes effect.

4.4.2.2. Withholding from any salary continuation check for a paid leave of absence that is considered as part of the Participant's FMLA leave.

4.4.2.3. Monthly payment by the Participant to the Participating Employer from the Participant's own funds either at the same time it would be made if by payroll deduction or on the same schedule as payments are made for COBRA compensation coverage.

4.4.2.4. Payment through the Cafeteria Plan.

4.4.2.5. By any other method mutually agreeable to the Participant and the Participating Employer, including (where the leave is foreseeable) increased withholding from one or more of the Participant's regular paychecks preceding the leave to pay in advance the required premiums during the leave.

The Participating Employer's obligation to provide ongoing coverage under this Plan for a Participant on an FMLA ceases if the Participant is more than thirty (30) days late on

making a required premium payment, provided, however, that the Participating Employer may (at its option) cover a Participant's missed payments so that coverage will be uninterrupted. In this event, the Participating Employer's advances may be recovered under the terms of Section 4.4.1 in the event the Participant voluntarily terminates his or her employment under circumstances within the Participant's control.

4.5. Use of Contributions. Participating Employer and Participant contributions may be used to provide Benefits directly or may be used to purchase insurance or other contracts to provide Benefits as determined by the Sponsor.

4.6. Subrogation.

4.6.1. If a Participant or Dependent receives any Benefits arising out of an injury or illness for which the Participant or Dependent (or the Participant's or Dependent's guardian, estate or trustee) has, may have, or asserts any claim or right to recovery against a third party or parties, then any payment or payments under the Plan for such Benefits shall be made on the condition and with the understanding that the Plan will be reimbursed in full, and in first priority, out of the recovery from any policy, proceeds, judgment or settlement on account of such injury or illness. Such reimbursement will be made by the Participant or Dependent (or the Participant's or Dependent's guardian, estate or trustee) out of the recovery made from the third party or insurer to the extent of, but not exceeding, the total amount payable to or on behalf of the Participant or Dependent (or the Participant's or Dependent's guardian, estate or trustee) from: (i) any policy or contract from any insurance company or carrier (including the Participant's or Dependent's insurer); and/or (ii) any third party, plan, or fund as a result of a judgment or settlement. The Participant or Dependent on behalf of himself or herself (and his or her guardian, estate or trustee) acknowledges and agrees that the Plan will be reimbursed in full before any amounts (including attorney fees incurred by the Participant or Dependent or his or her guardian, estate or trustee) are deducted from the policy, proceeds, judgment, or settlement and specifically rejects, and agrees not to seek application of the "make whole," "common fund" or other similar apportionment theory in any suit, action or proceeding that would affect the reimbursement or subrogation rights of the Plan.

4.6.2. The Plan will be subrogated to all claims, demands, actions, and rights of recovery against any entity, including, but not limited to, third parties and insurance companies and carriers (including the Participant's or Dependent's insurer) to the fullest extent permitted by law in the appropriate jurisdiction. The amount of such subrogation will equal the total amount paid under the Plan arising out of the injury or illness for which the Participant or Dependent (or the Participant's or Dependent's guardian or estate or any applicable trust) has, may have, or asserts a cause of action. In addition, the Plan will be subrogated for attorney's fees incurred in enforcing its subrogation rights under this Section.

The Participant or Dependent on behalf of himself (or his guardian or estate or any applicable trust) specifically agrees to do nothing to prejudice the Plan's rights to reimbursement or subrogation. In addition, the Participant or Dependent on behalf of himself (or his guardian or estate or any applicable trust) agrees to cooperate fully with the Plan and

Administrator in asserting and protecting the Plan's subrogation rights. The Participant or Dependent on behalf of himself or herself (or his or her guardian or estate or any applicable trust) agrees to execute and deliver all instruments and papers (in their original form) and do whatever else is necessary to fully protect the Plan's subrogation rights.

4.6.3. The Participant or Dependent specifically agrees on behalf of himself or herself (or his or her guardian or estate or any applicable trust) to notify the Administrator, in writing, of whatever Benefits are paid under the Plan that arise out of any injury or illness that provides or may provide the Plan reimbursement or subrogation rights under this Section.

4.6.4. Failure to comply with the requirements of this Section by the Participant or Dependent (or his or her estate or guardian or any applicable trust) may, at the Administrator's discretion, result in a forfeiture of Benefits under the Plan.

ARTICLE V. CLAIMS PROCEDURE

Any claim for Benefits under any of the Benefit Programs shall be made in accordance with the procedures as set forth in the Applicable Contracts or Summary Plan Description and in accordance with the procedure set forth below. To the extent the procedures set forth in the Applicable Contracts or Summary Plan Description of a Benefit Program provide a Claimant with a more generous time frame in which to submit a claim, appeal or additional levels of appeal, than otherwise required by the procedures set forth below, the procedures set forth in the Applicable Contracts or Summary Plan Description shall control.

5.1. Claims Procedure. All claims submitted with respect to a Benefit Program shall be processed in accordance with the rules of this Section 5.1.

5.1.1. General Procedures. The Administrator shall establish administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with the governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated Claimants. A Participant, Beneficiary or Dependent may designate another individual to act as his or her authorized representative with respect to the processing of a claim for Benefits under the Plan by providing a written notice of such authorization to the Administrator in the form and manner designated by the Administrator. Such designation must provide reasonable detail regarding the identity of the authorized representative. A Participant, Beneficiary or Dependent may have only one authorized representative at any time.

5.1.2. Initial Claim

5.1.2.1. Filing a Claim. A Claimant who believes that he or she is entitled to past, current or future Benefits or who has any other claim with respect to the Plan and who has not received those Benefits may claim those Benefits by submitting to the Claims Fiduciary a written notification of his or her claim of right to such Benefits in the manner prescribed by the Claims Fiduciary. In reviewing claims, the Claims Fiduciary shall have full

discretionary authority to determine all questions (including questions of fact) arising in the administration, interpretation and application of the Plan. In all cases, the Claims Fiduciary's decision shall be final and binding upon all parties.

5.1.2.2. Timing of Benefit Determinations. Except as provided below, if a claim is wholly or partially denied, the Administrator shall notify the Claimant of the Claims Fiduciary's Adverse Benefit Determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan, unless the Administrator determines that special circumstances require an extension of time for processing the claim. If the Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Fiduciary expects to render a decision on the claim. Any claim not granted or denied within the period noted above shall be deemed to have been denied.

5.1.2.3. Urgent Care Claims. In the case of an Urgent Care Claim, the Administrator shall notify the Claimant of the Claims Fiduciary's determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, Benefits are payable under the Plan. In case of such a failure, the Administrator shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours to provide the specified information. The Administrator shall notify the Claimant of the Claims Fiduciary's determination as soon as possible, but in no case later than 48 hours after the earlier of:

5.1.2.3.1. the Plan's receipt of the specified information; or

5.1.2.3.2. the end of the period afforded the Claimant to provide the specified additional information.

5.1.2.4. Concurrent Care Decision. If a Benefit Program that is a Group Health Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, then:

5.1.2.4.1. any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination, and the Administrator shall notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the Benefit is reduced or terminated.

5.1.2.4.2. any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is an Urgent Care Claim shall be decided as soon as possible, taking into account the medical exigencies, and the Administrator shall notify the Claimant of the Claims Fiduciary's determination (whether adverse or not), within 24 hours after receipt of the claim by the Plan, provided that such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

5.1.2.4.3. Notification of an Adverse Benefit Determination concerning a request to extend the course of treatment and the appeal of any such Adverse Benefit Determination shall be made in accordance with Section 5.1.4 and Section 5.1.5 respectively.

5.1.2.5. Group Health Plan Pre-Service Claims.

5.1.2.5.1. In the case of a Pre-Service Claim, the Administrator shall notify the Claimant of the Claims Fiduciary's determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time for up to 15 days, provided the Administrator both determines that such an extension is necessary due to matters beyond the Plan's control and notifies the Claimant, prior to the expiration of the initial 15 day period, of the circumstances requiring the extension of time and the date by which the Claims Fiduciary expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded 45 days from receipt of the notice within which to provide the specified information.

5.1.2.5.2. If the Claimant fails to follow the procedures for filing a Pre-Service Claim, the Claimant shall be notified of the failure and the proper procedures to be followed in filing a claim for Benefits. This notification shall be provided to the Claimant, as soon as possible, but not later than 5 days (24 hours in the case of an Urgent Care Claim) following the failure. Notification may be oral, unless written notification is requested by the Claimant. This Section shall apply only in the case of a failure that: (i) is a communication by a Claimant that is received by a person or organizational unit customarily responsible for handling Benefit matters; and (ii) is a communication that names a specific Claimant, a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

5.1.2.6. Group Health Plan Post Service Claims. In the case of a Post-Service Claim, the Administrator shall notify the Claimant of the Claims Fiduciary's Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the Plan's control and notifies the Claimant, prior to the expiration of the initial 30-day period, of the

circumstances requiring the extension of time and the date by which the Claims Fiduciary expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded 45 days from receipt of the notice within which to provide the specified information.

5.1.2.7. Disability Claims. In the case of a claim for disability Benefits, the Administrator shall notify the Claimant of the Claims Fiduciary's Adverse Benefit Determination within a reasonable period of time, not later than 45 days after receipt of the claim by the Plan. This period may be extended for up to 30 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the Plan's control and notifies the Claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Claims Fiduciary expects to render a decision. If, prior to the end of the first 30-day extension period, the Administrator determines that, due to matters beyond the Plan's control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Administrator notifies the Claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claims Fiduciary expects to render a decision. In the case of any extension under this Section 5.1.2.7, the notice of extension shall specifically explain the standards on which entitlement to a Benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the Claimant shall be afforded 45 days within which to provide the specified information.

5.1.3. Timing of Benefit Determinations. For purposes of this Article, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to Section 5.1.2 due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be suspended from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

5.1.4. Manner and Content of Notice of Adverse Benefit Determination. The Claims Fiduciary and any other person(s) involved in adjudicating all initial claims determinations must be independent and impartial. Decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to the Claims Fiduciary and any other claims adjudicator or medical expert cannot be based upon the likelihood that these individuals will support a denial of benefits. A medical expert will be contracted based on the expert's professional qualifications and not on the expert's reputation for outcomes in contested cases. Except as provided in Section 5.1.4.3, the Claimant will be provided with written or electronic notification of any Adverse Benefit Determination.

5.1.4.1. General Notification Rules. An Adverse Benefit Determination notice provided to the Claimant shall set forth, in a manner calculated to be understood by the Claimant:

5.1.4.1.1. the specific reason or reasons for the Adverse Benefit Determination;

5.1.4.1.2. reference to the specific Plan provisions on which the Adverse Benefit Determination is based;

5.1.4.1.3. 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; and

5.1.4.1.4. a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review.

5.1.4.2. Group Health Plan Notification Rules. In addition to the requirements of Section 5.1.4.1, with respect to any claim under a Benefit Program that is a Group Health Plan, an Adverse Benefit Determination notice provided to the Claimant must also comply with the following:

5.1.4.2.1. be written in a culturally and linguistically appropriate manner;

5.1.4.2.2. include information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code, the treatment code and the corresponding meaning of these codes;

5.1.4.2.3. include the specific reason or reasons for the Adverse Benefit Determination, the denial code and its corresponding meaning;

5.1.4.2.4. a description of the Plan's standard or the specific Group Health Plan provision on which the Adverse Benefit Determination is based;

5.1.4.2.5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request;

5.1.4.2.6. if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Group Health Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

5.1.4.2.7. provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal and the time limits applicable to such procedures;

5.1.4.2.8. provide the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist enrollees with internal claims and appeals and external review processes; and

5.1.4.2.9. in the case of an Adverse Benefit Determination concerning an Urgent Care Claim, a description of the expedited review process applicable to such claim.

5.1.4.3. Urgent Care Claims. In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, the information described in Sections 5.1.4.1 and 5.1.4.2 may be provided to the Claimant orally within the time frame prescribed in Section 5.1.2.3, provided that a written or electronic notification in accordance with Sections 5.1.4.1 and 5.1.4.2 is furnished to the Claimant not later than 48 hours after the oral notification.

5.1.4.4. Disability Benefit Notification Rules. In addition to the requirements of Section 5.1.4.1, in the case of an Adverse Benefit Determination with respect to a claim for disability Benefits, an Adverse Benefit Determination notice provided to the Claimant must also comply with the following:

5.1.4.4.1. be written in a culturally and linguistically appropriate manner;

5.1.4.4.2. include a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the Adverse Benefit Determination, and (iii) a disability determination regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration;

5.1.4.4.3. if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the

Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

5.1.4.4.4. either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

5.1.4.4.5. 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 Claimant's claim for disability Benefits.

5.1.5. Appeal of Adverse Benefit Determinations.

5.1.5.1. Full and Fair Review. Except as provided below, the Plan shall:

5.1.5.1.1. provide the Claimant 60 days following receipt of notification of an Adverse Benefit Determination within which to appeal the determination;

5.1.5.1.2. provide the Claimant the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

5.1.5.1.3. provide the Claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for Benefits;

5.1.5.1.4. provide for a review that takes 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 benefit determination.

5.1.5.2. Group Health Plan and Disability Benefit Claims. In addition to complying with the requirements of Sections 5.1.5.1.2 through 5.1.5.1.4 above, with respect to any claim under a Benefit Program that is a Group Health Plan or any claim involving disability Benefits, the Plan shall:

5.1.5.2.1. provide the Claimant 180 days following receipt of a notification of an Adverse Benefit Determination within which to appeal the determination;

5.1.5.2.2. provide for a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by the Appeals Fiduciary who is neither the Claims Fiduciary, nor the subordinate of the Claims Fiduciary;

5.1.5.2.3. provide that, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including

determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Appeals Fiduciary shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

5.1.5.2.4. provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;

5.1.5.2.5. provide that the Health Care Professional engaged for purposes of a consultation under Section 5.1.5.2.3 shall be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;

5.1.5.2.6. as soon as possible and sufficiently in advance of issuing a notice of Adverse Benefit Determination on review, provide the Claimant, free of charge, any new or additional evidence considered, relied upon, or generated by the Appeals Fiduciary (or at the direction of the Appeals Fiduciary) in connection with the claim so that the Claimant has a reasonable opportunity to respond prior to receiving such notice;

5.1.5.2.7. as soon as possible and sufficiently in advance of issuing a notice of Adverse Benefit Determination on review based on a new or additional rationale, provide the rationale to the Claimant, free of charge, so that the Claimant has a reasonable opportunity to respond prior to receiving such notice; and

5.1.5.2.8. provide, in the case of an Urgent Care Claim, for an expedited review process pursuant to which: (i) a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant; and (ii) all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

5.1.6. Timing of Notification of Benefit Determination on Review.

5.1.6.1. Except as provided below, the Administrator shall notify a Claimant in accordance with Section 5.1.7, of the Plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the Claimant's request for review by the Plan, unless the Administrator determines that special circumstances require an extension of time for processing the claim. If the Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Appeals Fiduciary expects to render the determination on review.

5.1.6.2. Group Health Plan. With respect to the review of an Adverse Benefit Determination under a Group Health Plan, the Administrator shall notify a Claimant of the Plan's benefit determination in accordance with this Section, as appropriate.

5.1.6.2.1. Urgent Care Claims. In the case of an Urgent Care Claim, the Administrator shall notify the Claimant, in accordance with Section 5.1.7, of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an Adverse Benefit Determination by the Plan.

5.1.6.2.2. Pre-Service Claims. In the case of a Pre-Service Claim, the Administrator shall notify the Claimant, in accordance with Section 5.1.7, of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances but not later than 30 days after receipt by the Plan of the Claimant's request for review of an Adverse Benefit Determination.

5.1.6.2.3. Post-Service Claims. In the case of a Post-Service Claim, the Administrator shall notify the Claimant, in accordance with Section 5.1.7, of the Plan's benefit determination on review within a reasonable period of time not later than 60 days after receipt of the Plan of the Claimant's request for review of an Adverse Benefit Determination.

5.1.6.3. Disability Claims. Claims involving disability Benefits shall be governed by Section 5.1.6.1, except that a period of 45 days shall apply instead of 60 days for purposes of that Section.

5.1.6.4. Calculating time periods. For purposes of this Section the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed, in accordance with the Plan's procedures, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be suspended from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

5.1.6.5. Furnishing documents. In the case of an Adverse Benefit Determination on review, the Administrator shall provide such access to, and copies of, documents, records, and other information as appropriate.

5.1.7. Manner and Content of Notification of Benefit Determination on Review. The Appeals Fiduciary and any other person(s) involved in adjudicating all appeals must be independent and impartial. Decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to the Appeals Fiduciary and any other claims adjudicator or medical expert cannot be based upon the likelihood that these individuals will support a denial of

Benefits. A medical expert will be contracted based on the expert's professional qualifications and not on the expert's reputation for outcomes in contested cases.

5.1.7.1. General Notification Rules. The Administrator shall provide a Claimant with written or electronic notification of the Appeals Fiduciary's benefit determination on review. With respect to any claim on review, an Adverse Benefit Determination notice provided to the Claimant shall set forth, in a manner calculated to be understood by the Claimant:

5.1.7.1.1. the specific reason or reasons for the Adverse Benefit Determination;

5.1.7.1.2. reference to the specific Plan provisions on which the Adverse Benefit Determination is based;

5.1.7.1.3. 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 Claimant's claim for Benefits; and

5.1.7.1.4. a statement of the Claimant's right to bring an action under section 502(a) of ERISA.

5.1.7.2. Group Health Plan Notification Rules. In addition to the requirements of Section 5.1.7.1, with respect to any appeal under a Benefit Program that is a Group Health Plan, an Adverse Benefit Determination notice provided to the Claimant must also comply with the following:

5.1.7.2.1. be written in a culturally and linguistically appropriate manner;

5.1.7.2.2. include information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code, the treatment code and the corresponding meaning of these codes;

5.1.7.2.3. include the reason for the Adverse Benefit Determination on review, the denial code and its corresponding meaning;

5.1.7.2.4. include a description of the Plan's standard or the specific Group Health Plan provision, if any, that was relied upon in denying the claim on review;

5.1.7.2.5. include a discussion of the final decision on review;

5.1.7.2.6. provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal and the time limits applicable to such procedures;

5.1.7.2.7. provide the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist enrollees with internal claims and appeals and external review processes;

5.1.7.2.8. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, provide either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;

5.1.7.2.9. if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Group Health Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

5.1.7.2.10. 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."

5.1.7.3. Disability Benefit Notification Rules. In addition to the requirements of Section 5.1.7.1, with respect to any appeal of a claim for disability Benefits, an Adverse Benefit Determination notice provided to the Claimant on review must comply with the following:

5.1.7.3.1. be written in a culturally and linguistically appropriate manner;

5.1.7.3.2. include a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the Claimant to the Plan of Health Care Professionals treating the Claimant and vocational professionals who evaluated the Claimant, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the Adverse Benefit Determination, and (iii) a disability determination regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration;

5.1.7.3.3. if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

5.1.7.3.4. provide either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Benefit Determination on review or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

5.1.7.3.5. a description of any contractual limitation that applies to the Claimant's right to bring an action under section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires for the disability claim.

5.2. External Review. In accordance with Department of Labor Technical Release 2011-02, if a State external review process applies to, and is binding on, a health insurance issuer providing Benefits under an insured Benefit Program that is a Group Health Plan, as provided under Treasury Regulation § 54.9815-2719T(c) then it is the health insurance issuer, not the insured Benefit Program or Group Health Plan, that is required to provide an external review process (by complying with either the State external review process or the Federal external review process). Except as otherwise provided under an Applicable Contract, to the extent that a Benefit Program that is a Group Health Plan provides Benefits other than through health insurance coverage and is otherwise not required to comply with the State external review process, then the Group Health Plan will comply with the Federal external review process as provided under Treasury Regulation § 54.9815-2719T(d) and as summarized below.

5.2.1. Standard External Review and Requesting a Standard External Review. This Section sets forth procedures for standard external review. A standard external review is an external review procedure that is not considered expedited (as described below). The external review process shall apply only to claims that involve (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer, or (2) a Rescission of Coverage. After exhausting the internal claims procedures, a Claimant may file a request for an external review with a Benefit Program that is a Group Health Plan if the request is filed within four months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice.

5.2.1.1. Preliminary Review of Request for Standard External Review. Within five business days following the date of receipt of the external review request, the Group Health Plan will complete a preliminary review of the request to determine whether:

5.2.1.1.1. The Claimant is or was covered under the Group Health Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Group Health Plan at the time the health care item or service was provided;

5.2.1.1.2. The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Group Health Plan (e.g., worker classification or similar determination);

5.2.1.1.3. The Claimant has exhausted the Group Health Plan's internal appeal process; except that the process will not be deemed exhausted for minor errors that are (1) de minimis, (2) non-prejudicial or unlikely to cause harm, (3) attributable to good cause or matters beyond the Plan's or issuer's control, (4) made in the context of an ongoing, good-faith exchange of information, and (5) not reflective of a pattern or practice of noncompliance. In such case, the Group Health Plan will disclose the basis for its determination. If an external reviewer or court rejects a Claimant's request for immediate review on the basis of this standard, the Claimant will be able to resubmit the claim to the Plan for completion of the internal appeal process. However, if the Group Health Plan fails to strictly adhere to the notice provisions contained in Section 5.1, the Claimant is deemed to have exhausted the Group Health Plan's internal claims and appeals process; and

5.2.1.1.4. The Claimant has provided all the information and forms required to process a standard external review.

5.2.1.2. Response to Request for Standard External Review. Within one business day after completion of the preliminary review, the Group Health Plan must issue a notification in writing to the Claimant. If the request is complete but not eligible for standard external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, such notification must describe the information or materials needed to make the request complete and the Group Health Plan must allow a Claimant to perfect the request for external review within the four-month filing period or, if later, within 10 business days following the receipt of the notification.

5.2.1.3. Referral to Independent Review Organization. Upon a finding that the Claimant is eligible for a standard external review, the Group Health Plan will assign an independent review organization ("IRO") that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Group Health Plan will take action against bias and to ensure independence. The Group Health Plan will contract with at least three IROs for assignments under the Group Health Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. The contract between the Group Health Plan and an IRO will provide the following:

5.2.1.3.1. The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Group Health Plan.

5.2.1.3.2. The assigned IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for standard external review. This notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the standard external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

5.2.1.3.3. Within five business days after the date of assignment of the IRO, the Group Health Plan must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination. Failure by the Group Health Plan to timely provide the documents and information must not delay the conduct of the standard external review. If the Group Health Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or final internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify the Claimant and the Group Health Plan.

5.2.1.3.4. Upon receipt of any information submitted by the Claimant, the assigned IRO must within one business day forward the information to the Group Health Plan. Upon receipt of any such information, the Group Health Plan may reconsider its Adverse Benefit Determination or final internal Adverse Benefit Determination that is the subject of the standard external review. Reconsideration by the Group Health Plan must not delay the standard external review. The standard external review may be terminated as a result of the reconsideration only if the Group Health Plan decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or final internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Group Health Plan must provide written notice of its decision to the Claimant and the assigned IRO. The assigned IRO must terminate the standard external review upon receipt of the notice from the Group Health Plan.

5.2.1.3.5. The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Group Health Plan's internal claims and appeals process applicable under paragraph (b) of Treasury Regulation § 54.9815-2719T. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- (i) the Claimant's medical records;
- (ii) the attending Health Care Professional's recommendation;

(iii) reports from appropriate Health Care Professionals and other documents submitted by the Group Health Plan, Claimant, or the Claimant's treating provider;

(iv) the terms of the Group Health Plan ensure that the IRO's decision is not contrary to the terms of the Group Health Plan, unless the terms are inconsistent with applicable law;

(v) appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;

(vi) any applicable clinical review criteria developed and used by the Group Health Plan, unless the criteria are inconsistent with the terms of the Group Health Plan or with applicable law; and

(vii) the opinion of the IRO's clinical reviewer or reviewers after considering the information described above to the extent the information or documents are available and the clinical reviewer or reviewers consider them appropriate.

5.2.1.3.6. The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the standard external review. The IRO must deliver the notice of final external review decision to the Claimant and the Group Health Plan.

5.2.1.3.7. The assigned IRO's decision notice will contain:

(i) a general description of the reason for the request for standard external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(ii) the date the IRO received the assignment to conduct the standard external review and the date of the IRO decision;

(iii) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(iv) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(v) a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Group Health Plan or to the Claimant;

(vi) a statement that judicial review may be available to the Claimant; and

(vii) current contact information, including phone number, of any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

5.2.1.3.8. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claimant, the Group Health Plan, or any State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

5.2.1.3.9. Reversal of Group Health Plan's Decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, the Group Health Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim, regardless of whether the Group Health Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

5.2.2. Expedited External Review.

5.2.2.1. Request for Expedited External Review. A Claimant may make a request for an expedited external review with the Group Health Plan at the time the Claimant receives:

5.2.2.1.1. an Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

5.2.2.1.2. a final internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

5.2.2.2. Preliminary Review of an Expedited External Review Request.

Immediately upon receipt of the request for expedited external review, the Group Health Plan will determine whether the request meets the requirements set forth above in Section 5.2.1.1 for a preliminary standard external review and also the requirements in Section 5.2.2.1 for an expedited external review.

5.2.2.3. Referral to Independent Review Organization.

Upon a determination that a request is eligible under both the requirements for a standard external review and an expedited external review, the Group Health Plan will assign an IRO pursuant to the requirements set forth above in Section 5.2.1.3 for standard external review. The Group Health Plan must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Group Health Plan's internal claims and appeals process.

5.2.2.4. Notice of Final External Review Decision.

The Group Health Plan's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claimant and the Group Health Plan.

5.3. Litigation. In order to operate and administer the claims procedure in a timely and efficient manner, a Claimant may not commence any legal action in any way relating to the Plan, including but not limited to a claim for benefits or for a breach of fiduciary duty, until the Claimant has exhausted his or her rights and remedies under the Plan's claims procedures described above. If a Claimant or other authorized individual desires to commence a legal action with respect to any claim relating to the Plan, he or she must do so in the United States District Court for the Eastern District of Pennsylvania in Philadelphia, Pennsylvania, where the Plan is administered, and such action must be commenced within one year after receipt of notification of the denial of his or her claim. A Claimant will not be permitted to introduce any new facts or legal theories that were not presented during the claim review process. In addition, to the maximum extent permitted by law, all claims or legal actions in any way relating to the Plan must be made on an individual basis and may not be brought as a class or collective action or in a representative capacity on behalf of any person or entity. Failure to bring a timely court action in the proper venue will forever bar the commencement of such action.

ARTICLE VI. ADMINISTRATION

6.1. Fiduciary Responsibility. The Plan shall be administered by the Administrator. The Administrator shall administer the Plan and shall be a “named fiduciary” and “administrator” of the Plan, as those terms are defined by ERISA, and its agent designated to receive service of process.

6.2. Duties and Powers of the Administrator. The Administrator shall have the exclusive power and authority in its sole and absolute discretion to control and manage the operation and administration of the Plan and shall have all powers necessary to accomplish these purposes. The responsibility and authority of the Administrator shall include, but shall not be limited to, the following duties and powers: (a) to construe and interpret the Plan and decide any matters arising hereunder; (b) to prescribe procedures to be followed by Participants in making elections under the Plan; (c) to prepare and distribute information explaining the Plan to Participants; (d) to receive from Participating Employers and from Participants such information as shall be necessary for the proper administration of the Plan; (e) to furnish Participating Employers and Participants such information as shall be necessary for the proper administration of the Plan; (f) to keep reports of elections, claims and disbursements for claims under the Plan, as appropriate; (g) to employ such persons including but not limited to actuaries, accountants, consultants and legal counsel, as it deems appropriate to perform such duties as may from time to time be required under ERISA or the Code and to render advice upon request with regard to any matters arising under the Plan; (h) to accept, modify or reject elections under the Plan; (i) to prepare and file any reports or returns with respect to the Plan required by applicable law; and (j) to take all other steps deemed necessary to properly administer the Plan in accordance with its terms and the requirements of applicable law.

6.3. Rules and Decisions. The Administrator may adopt such rules and procedures as it deemed necessary, desirable or appropriate in the administration of the Plan, provided that such rules and procedures do not conflict with the Plan or applicable law. All rules and decisions of the Administrator shall be uniformly and consistently applied to all Participants in similar circumstances and shall be conclusive and binding on all persons having an interest in the Plan. When making any decision or determination, the Administrator shall be entitled to consider such information as may be furnished to it by a Participant, a Participating Employer, legal counsel or the administrator of any Benefit Program which is subject to the Plan.

Any final determination by the Administrator shall be binding on all parties. If challenged in court, such determination shall not be subject to de novo review and shall not be overturned unless proven to be arbitrary and capricious upon the evidence presented to the Administrator at the time of his determination.

6.4. Applicable Contracts. The Administrator shall have the authority to enter into any contract or agreement or execute any document to provide Benefits under the Plan. Any such contract, agreement or document shall be considered an Applicable Contract and shall be incorporated herein without amending the Plan document.

6.5. Authority to Conform to Requirements of the Code. The Administrator shall administer the Plan in such a manner as to ensure that it does not discriminate in favor of Restricted Employees, and that it is in compliance with any nondiscrimination requirement imposed by the Code.

6.6. Exclusive Benefit Rule. The Administrator shall administer the Plan for the exclusive benefit of Participants and their Dependents.

6.7. Indemnification of Plan Fiduciaries. The Sponsor agrees to indemnify and defend to the fullest extent of the law any employee, former employee, or member of the Board of Directors who serves or has served as the Administrator or otherwise exercises or has exercised fiduciary responsibilities with respect to the Plan against any liabilities, damages, costs and expenses occasioned by his or her having acted in such capacity in good faith.

ARTICLE VII. AMENDMENT AND TERMINATION OF THE PLAN

7.1. Amendment.

7.1.1. The Plan and any and all Benefit Programs may be amended at any time and from time to time by the Sponsor or the Administrator. An amendment may include a reduction in coverage or Benefits available under the Plan.

7.1.2. In addition, the Administrator may prepare and execute on behalf of each Participating Employer, all technical, administrative, regulatory and compliance amendments to the Plan, that the Administrator, with appropriate advice of counsel or other benefits consultants, determine to be necessary or appropriate for the administration, operation or continued tax-exempt status of the Plan. The Administrator may revise any Applicable Contract, Summary Plan Description or any provision of the Plan as necessary to reflect any necessary administrative changes in the operation of the Plan.

7.2. Termination. The Sponsor shall have the right to terminate the Plan and any or all Benefit Programs at any time. Each Participating Employer reserves the right to cease participating in the Plan or cease offering any Benefit Program at any time with respect to its Eligible Employees. In the case of a termination or cessation of participation, no individual employed by a Participating Employer may thereafter be admitted to the Plan as a Participant, and neither the Participating Employer nor any individual shall have any liability or obligation to make any further contributions or provide additional Benefits under the Plan. If a Participating Employer ceases to be an Employer, its participation in the Plan shall immediately terminate and its employees shall immediately cease to be Participants under each Benefit Program except as may otherwise be required by law.

7.3. Application of Authority to Amend and Terminate Plan. The authority of the Sponsor and the Administrator to amend or terminate the Plan or any Benefit Program as described above, and the authority of each Participating Employer to cease offering the Plan or any Benefit Program as to its Eligible Employees, shall exist with respect to a Participant or

Dependent regardless of such individual's period of service or employment status and regardless of whether such individual has retired from a Participating Employer, become a terminated or retired Participant or otherwise ceased to be an Eligible Employee.

ARTICLE VIII. MISCELLANEOUS

8.1. Limited Purpose of Plan. The establishment or existence of the Plan shall not confer upon any Eligible Employee the right to be continued as an employee. Each Participating Employer expressly reserves the right to discharge any Eligible Employee whenever in its judgment its best interests so require.

8.2. Gender. The masculine gender shall incorporate the feminine.

8.3. Nonalienation. No benefit payable under the Plan shall be subject in any manner to anticipation, assignment, or voluntary or involuntary alienation.

8.4. Facility of Payment. If the Administrator, in its sole discretion, deems a Participant or Dependent who is entitled to receive any payment hereunder to be incompetent to receive the same by reason of age, illness or any infirmity or incapacity of any kind, the Administrator may apply such payment directly for the benefit of such person, or make payment to any person selected by the Administrator to disburse the same for the benefit of the Participant or his or her Dependent. Payments made pursuant to this Section shall operate as a discharge, to the extent thereof, of all liabilities of the Participating Employer and the Plan to the person for whose benefit the payments are made.

8.5. Governing Law. Except to the extent such laws are superseded by ERISA, the laws of the Commonwealth of Pennsylvania shall govern without regard to the principles of conflict of laws thereof.

8.6. Invalidity. If any provision of the Plan shall be invalid or unenforceable to any extent, the remainder of the Plan shall not be affected thereby and shall be enforceable to the fullest extent of the law.

8.7. Extension of Certain ERISA Deadlines. The period ending on the earlier of: (1) one year from the date the applicable ERISA deadline would have occurred on or after March 1, 2020, or (2) sixty days after the announced end of the COVID-19 National Emergency or such other date announced by the Department of Labor and the Department of the Treasury, shall be disregarded in determining: (a) the date within which individuals may file a benefit claim and claimants may file an appeal of an adverse benefit determination under the plan's claims procedure; (b) the 30-day period (or 60-day period, if applicable) to request special enrollment; (c) the 60-day election period for COBRA continuation coverage; (d) the date for making COBRA premium payments; (e) the date for individuals to notify the Plan of a qualifying event or determination of disability; (f) the date within which claimants may file a request for an external review after receipt of a final internal adverse benefit determination; (g) the date within which a claimant may file information to perfect a request for external review upon a finding that the request was not

complete; and (h) the date by which a COBRA election notice must be provided to an eligible individual.

ARTICLE IX. HIPAA PRIVACY AND SECURITY REQUIREMENTS

9.1. Protected Health Information: Duties of the Sponsor. The Plan offers both HIPAA covered and non-covered Benefit Programs. As a result, HIPAA may treat the Plan as offering a healthcare component and a non-healthcare component and consequently the Plan may be considered a “hybrid entity” under HIPAA. In such event, those Benefit Programs that are a Group Health Plan will be treated as a separate healthcare component of the Plan. All Benefit Programs that are not a Group Health Plan are to be treated as non-covered benefits for purposes of HIPAA. The Plan and the Sponsor intend to comply with HIPAA with respect to only the healthcare component of the Plan and to ensure adequate separation between the healthcare component and the non-healthcare component. Therefore, to the extent required by HIPAA, the Plan and the Sponsor will comply with the safeguard requirements relating to hybrid entities. In addition, to the extent the Sponsor maintains more than one Group Health Plan, such Group Health Plans shall be treated as an Organized Health Care Arrangement for purposes of HIPAA compliance and may share Protected Health Information with each other for health care operation purposes and may issue a joint notice of privacy practices.

9.1.1. Use and Disclosure of Protected Health Information. The Sponsor may use and disclose Protected Health Information received from the Plan, or received by the Sponsor on behalf of the Plan from a health insurance issuer or HMO, solely for Plan administrative functions and solely as permitted or required by the Plan or as otherwise required by law. The Sponsor shall not use or disclose Protected Health Information received from the Plan, or received by the Sponsor on behalf of the Plan from a health insurance issuer or HMO, in any manner that would constitute a violation of the Privacy Standards.

9.1.2. Employment Decisions. The Sponsor agrees not to use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Sponsor.

9.1.3. Reporting of Disclosures of Protected Health Information. The Sponsor shall report to the Plan after becoming aware of any use or disclosure of Protected Health Information by the Sponsor that is inconsistent with the terms and provisions of the Plan and the Privacy Standards.

9.1.4. Third Parties. The Sponsor shall obtain the written agreement of any Business Associate, agent or subcontractor that will have access to Protected Health Information that is received from the Plan, or received by the Sponsor on behalf of the Plan from a health insurance issuer or HMO, to be bound by the same restrictions and conditions that apply to Sponsor with respect to such Protected Health Information.

9.1.5. Access to Information and Accounting of Disclosures. The Sponsor shall make Protected Health Information held by the Sponsor available to the Plan as the Plan may

require to fulfill the Plan's obligations to provide access to, provide a copy of, and account for disclosures with respect to Protected Health Information pursuant to the Privacy Standards, including but not limited to 45 C.F.R. §164.524 and §164.528, as amended from time to time.

9.1.6. Availability of Protected Health Information for Amendment. The Sponsor shall provide Protected Health Information held by the Sponsor in a Designated Record Set to the Plan as the Plan may require to fulfill the Plan's obligations to amend Protected Health Information pursuant to the Privacy Standards, including, but not limited to, 45 C.F.R. § 164.526, as amended from time to time, and the Sponsor shall, as directed by the Plan, incorporate any amendments to Protected Health Information held by the Sponsor.

9.1.7. Availability of Books and Records. The Sponsor hereby agrees to make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan, or received by the Sponsor on behalf of the Plan from a health insurance issuer or HMO, available to the Secretary of the Department of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Standards, subject to attorney-client and other applicable legal privileges.

9.1.8. Return of Protected Health Information. When no longer needed for the purpose for which disclosure of Protected Health Information to the Sponsor was made, the Sponsor shall return or destroy all Protected Health Information received from the Plan, or received by the Sponsor on behalf of the Plan from a health insurance issuer or HMO, and which the Sponsor still maintains in any form. The Sponsor shall not retain any copies of such Protected Health Information. If it is not feasible to return or destroy such Protected Health Information, the Sponsor agrees to limit any further uses and disclosures to those purposes that make it necessary for the Sponsor to retain the Protected Health Information.

9.1.9. Adequate Separation. There shall be "adequate separation" between the Sponsor and the Plan as follows:

9.1.9.1. Only the following Employees under the control of the Sponsor will be given access to Protected Health Information for Plan administrative functions: the Employees of the Sponsor's Office of Human Resources (collectively, the "Plan Employees").

9.1.9.2. Plan Employees may only access and use Protected Health Information for Plan administrative functions that the Sponsor performs on behalf of the Plan and such services will be further limited by the requirements set forth and described in the Haverford College HIPAA Policy and Procedure Manual, as amended from time to time; and

9.1.9.3. The mechanism set forth in Section 9.1.10 shall be used to resolve any issues of noncompliance with the provisions of this Article by Plan Employees.

9.1.10. Non Compliance Resolution Mechanism. In the case of noncompliance with this Article by Plan Employees, the Director of Benefits Administration or other relevant supervisor may exercise his or her discretion in implementing an appropriate

noncompliance resolution mechanism including, but not limited to, the following: (i) educational discussion regarding appropriate handling of Protected Health Information and relevant policies and procedures; (ii) the action specified in Section 9.1.10(i), plus placing a warning notice in the Plan Employee's permanent employment record; (iii) placing the Plan Employee on probation; (iv) termination of the Plan Employee's employment with the Participating Employer; or (v) any other noncompliance resolution mechanism deemed appropriate by the Director of Benefits Administration or relevant supervisor, or under any Participating Employer disciplinary policy.

9.2. Protected Health Information: Duties of the Plan Employees on Behalf of the Plan. Unless otherwise authorized under an individual authorization described in the Privacy Standards, the Plan Employees shall treat Protected Health Information as follows:

9.2.1. Administrative Functions. The Plan Employees may disclose Protected Health Information to the Sponsor to carry out Plan administration functions that the Sponsor performs consistent with this Article.

9.2.2. Employment Decisions. The Plan Employees shall not disclose Protected Health Information to Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Sponsor that is not included in the Organized Health Care Arrangement.

9.2.3. Disclosures to the Sponsor.

9.2.3.1. The Plan Employees shall not permit a health insurance issuer or HMO to disclose Protected Health Information to the Sponsor except as permitted by this Article.

9.2.3.2. The Plan Employees shall not disclose and may not permit a health insurance issuer or HMO to disclose Protected Health Information to the Sponsor as otherwise permitted by this Section, unless a statement required by 45 C.F.R. § 164.520(b)(1)(iii)(B), as amended from time to time, (stating that the Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose Protected Health Information to Sponsor) is included in the appropriate Notice of Privacy Practices as required under the Privacy Standards.

9.2.4. Disclosure of Summary Health Information and Enrollment/Disenrollment Information. Notwithstanding anything in this Article IX to the contrary, the Plan Employees may disclose Summary Health Information, other than Genetic Information, to the Sponsor if the Sponsor requests the Summary Health Information for the purpose of obtaining premium bids from health insurance issuers for providing health insurance coverage under the Plan, or modifying, amending, or terminating the Plan. The Plan Employees also may disclose to the Sponsor information on whether an individual participates in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

9.2.5. Disclosure of Protected Health Information. The Plan Employees may disclose Protected Health Information to the Sponsor in connection with the Sponsor's certification in Section 9.5 and that the Sponsor agrees to abide by the provisions of this Article IX.

9.2.6. Business Associate Agreements. The Plan hereby authorizes the Sponsor to enter into Business Associate agreements, or amendments to such agreements, on the Plan's behalf, as necessary for the Plan's compliance with the Privacy and Security Standards.

9.3. Provisions Relating to the Security Standards for the Protection of Electronic Protected Health Information:

9.3.1. Safeguards for Electronic Protected Health Information. The Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information, if any, that the Sponsor creates, receives, maintains, or transmits on behalf of the Plan.

9.3.2. Security Measures for Adequate Separation. The Sponsor will support the "adequate separation" described above with reasonable and appropriate security measures.

9.3.3. Third Parties. The Sponsor shall obtain the written agreement of any Business Associate or agent that will have access to Electronic Protected Health Information to ensure implementation of reasonable and appropriate security measures to protect such information.

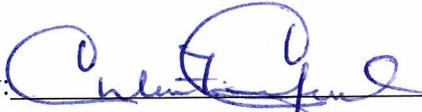
9.4. Reporting of Security Incidents or Breach of Unsecured Protected Health Information. The Sponsor will report to the Plan any Security Incidents or Breach of Unsecured Protected Health Information of which the Sponsor becomes aware that result in:
(a) unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information, (b) interference with Sponsor's information systems in a manner that may affect the Plan's Electronic Protected Health Information, or (c) as otherwise set forth and required by the Haverford College HIPAA Policy and Procedure Manual, as amended from time to time. For any other Security Incidents that do not result in unauthorized access, use, disclosure, modification, or destruction of Electronic Protected Health Information (including, for purposes of example and not for purposes of limitation, pings on Sponsor's firewall, port scans, attempts to log onto a system or enter a database with an invalid password or username, denial-of-service attacks, or malware such as worms or viruses), Sponsor shall aggregate the data and, upon the Plan's written request, report to the Plan.

9.5. Sponsor Certification. This Article IX shall serve as certification by the Sponsor that the Plan documents have been amended to incorporate the requirements under HIPAA 45 C.F.R. 164.504(f)(1) and that the Sponsor agrees to abide by the provisions of this Article IX.

* * * * *

To record the adoption of this amendment and restatement of the Plan, Haverford College has caused its authorized officer to affix its corporate name this 26 day of April, 2021.

HVERFORD COLLEGE

By: 
Charles F. Crawford
Director, Benefits Admin.

APPENDIX A

Applicable Contracts

As of January 1, 2021

BENEFIT PROGRAM	INSURER / THIRD PARTY ADMINISTRATOR	CONTRACT NO. OR POLICY
Basic Group Life and AD&D Insurance Program	Unum	691253
Dental Program*	Haverford College	N/A
Long-Term Care Program	Genworth	17292
Long-Term Disability Insurance Program*	Unum	335731
Medical Program		
- PPO Plan	IBC	10326450
- High Deductible Plans	IBC	10326453
- Health Maintenance Organizations	Keystone East	10101493
Vision Program	IBC	10326452
Voluntary Life and AD&D Insurance Program*	Unum	691254

*After-tax contributions only

APPENDIX B

Summary Plan Descriptions