DEPAUW UNIVERSITY
RETIREE WELFARE BENEFIT PLAN

Plan No. 516 Restated Effective January 1, 2014

TABLE OF CONTENTS

		Page
ARTICLE I.	**RESTATEMENT AND PURPOSE**	**1**
Section 1.01.	Restatement of Plan	1
Section 1.02.	Purpose of Plan	1
Section 1.03.	Retiree-Only Coverage	1
ARTICLE II.	**DEFINITIONS AND RULES OF INTERPRETATION**	**1**
Section 2.01.	Rules of Interpretation	1
Section 2.02.	Definitions	2
ARTICLE III.	**BENEFITS**	**8**
Section 3.01.	Employee Benefits	8
Section 3.02.	Insured Policies and Benefit Contracts Providing Employee Benefits	8
Section 3.03.	Uninsured Benefit Features	8
Section 3.04.	Incorporation of All Relevant Benefit Feature Documents	9
Section 3.05.	Termination, Addition, and Modification of Benefit Features	9
ARTICLE IV.	**CONTINUATION OF COVERAGE**	**9**
Section 4.01.	Election Between COBRA and Retiree Coverage	10
Section 4.02.	Applicability	11
Section 4.03.	Right to Continuation Coverage	11
Section 4.04.	Qualified Beneficiary	11
Section 4.05.	Qualifying Events	12
Section 4.06.	Election of Continuation Coverage	12
Section 4.07.	Period of Continuation Coverage	12
Section 4.08.	End of Continuation Coverage	12
Section 4.09.	Cost of Continuation Coverage	13
Section 4.10.	Notification Requirements	13
Section 4.11.	Continuation Health Benefits Provided	15
Section 4.12.	Bankruptcy Proceedings	15
ARTICLE V.	**LAWS AFFECTING BENEFIT FEATURES**	**15**
Section 5.01.	Health Insurance Portability and Accountability Act of 1996	15
Section 5.02.	Genetic Information Nondiscrimination Act of 2008	15
Section 5.03.	Newborns' and Mothers' Health Protection Act of 1996	16
Section 5.04.	Uniformed Services Employment and Reemployment Rights Act of 1994	16
ARTICLE VI.	**PROTECTED HEALTH INFORMATION**	**16**
Section 6.01.	Adoption and Effective Date	16
Section 6.02.	Supersession of Inconsistent Provisions	16
Section 6.03.	Use and Disclosure of Protected Health Information	16
Section 6.04.	Plan Documents	17

Section 6.05.	Disclosures by Plan to the University
Section 6.06.	Uses and Disclosures by the University
Section 6.07.	Certification
Section 6.08.	Conditions Agreed to by the University
Section 6.09.	Adequate Separation Between the Plan and the University
Section 6.10.	Limitations of Access and Disclosure
Section 6.11.	Noncompliance
ARTICLE VII.	**FUNDING POLICY AND CONTRIBUTIONS TO THE PLAN**
ARTICLE VIII.	**ADMINISTRATION OF THE PLAN**
Section 8.01.	Administrator
Section 8.02.	Claims Supervisor
Section 8.03.	Discretionary Authority of Administrator
Section 8.04.	Provision for Third-Party Administrative Service Providers
Section 8.05.	Timeliness of Benefit Payments
Section 8.06.	Designation of Fiduciaries
ARTICLE IX.	**CLAIMS PROCEDURES**
Section 9.01.	Coordination of Claims Procedures
Section 9.02.	Claims for Health Benefits
Section 9.03.	Claims for All Other Welfare Benefits Subject to ERISA
Section 9.04.	Claims Procedures Applicable for All Claims
ARTICLE X.	**SUBROGATION AND REIMBURSEMENT RIGHTS**
Section 10.01.	Right of Subrogation and Reimbursement
Section 10.02.	Funds to Which Subrogation and Reimbursement Rights Apply
Section 10.03.	Agreement to Hold Recovery in Trust
Section 10.04.	Disclaimer of Make Whole Doctrine
Section 10.05.	Disclaimer of Common Fund Doctrine
Section 10.06.	Obligations of the Covered Person
Section 10.07.	Plan's Right to Subrogation
Section 10.08.	Enforcement of Plan's Right to Reimbursement
Section 10.09.	Withholding of Payments for Benefits
Section 10.10.	Failure to Comply
Section 10.11.	Future Claims Excluded
Section 10.12.	Discretionary Authority of Administrator
ARTICLE XI.	**AMENDMENT OR TERMINATION PROCEDURE**
ARTICLE XII.	**MISCELLANEOUS**
Section 12.01.	Nonalienation
Section 12.02.	Additional Taxes or Penalties
Section 12.03.	No Guarantee of Tax Consequences
Section 12.04.	Requirement of Proper Forms
Section 12.05.	Limitation of Rights and Obligations
Section 12.06.	Notice
Section 12.07.	Disclaimer of Liability
Section 12.08.	Right of Recovery

Section 12.09. Legal Counsel
Section 12.10. Audit
Section 12.11. Bonding
Section 12.12. Protective Clause
Section 12.13. Receipt and Release
Section 12.14. Legal Actions
Section 12.15. Facility of Payment
Section 12.16. Reliance
Section 12.17. Misrepresentation
Section 12.18. Qualified Medical Child Support Orders
Section 12.19. Entire Plan

Schedule A ..... A - 1
Schedule B ..... B - 1
Schedule C ..... C - 1

DEPAUW UNIVERSITY RETIREE WELFARE BENEFIT PLAN

Article I. _
RESTATEMENT AND PURPOSE

Section 1.1. Restatement of Plan. DePauw University ("University") previously established the Emeriti Retiree Health Plan for DePauw University and the Emeriti Fully-Insured Retiree Health Plan for DePauw University, to provide for, among other things, certain welfare benefits for eligible retirees and their eligible dependents who were covered by the programs. These plans were part of a single plan entitled the Emeriti Retiree Health Program. The University has restated the Emeriti Retiree Health Plan for DePauw University effective January 1, 2013, and has renamed the plan the "DePauw University Retiree Health Plan and Trust." The University has also restated the Emeriti Fully-Insured Retiree Health Plan for DePauw University effective January 1, 2013, and has renamed the plan the "DePauw University Fully-Insured Retiree Health Plan and Trust." The University now desires to restate the Emeriti Retiree Health Program, effective January 1, 2014, and to rename the plan the "DePauw University Retiree Welfare Benefit Plan" ("Plan").

Section 1.2. Purpose of Plan. The purpose of the Plan is to provide certain employee benefits to Eligible Retirees of the University under the Plan.

Section 1.3. Retiree-Only Coverage. This Plan provides group health benefits for former employees of the University only, and, therefore, is not subject to the Patient Protection and Affordable Care Act of 2010 ("PPACA").

Article II. _
DEFINITIONS AND RULES OF INTERPRETATION

Section 2.1. Rules of Interpretation. In interpreting the Plan and any Benefit Feature under the Plan, the following rules of interpretation shall apply:

(a) The Plan and any Benefit Feature under the Plan shall be construed, enforced, and administered and the validity thereof determined in accordance with the Code and ERISA, and in accordance with the laws of the State of Indiana when such laws are not inconsistent with the Code or ERISA.

(b) Unless the context clearly indicates to the contrary, a reference to a statute, regulation, document or provision shall be construed as referring to any subsequently enacted, adopted or executed counterpart statute, regulation, document or provision.

(c) Any headings or subheadings in the Plan or a Benefit Feature are inserted for convenience of reference only and shall be ignored in the construction of any provisions of the Plan or Benefit Feature.

(d) Words used herein in the masculine gender shall be construed to include the feminine gender where appropriate and words used herein in the singular or plural shall be construed as being in the plural or singular where appropriate.

(e) If a provision of the Plan or Benefit Feature is held illegal or invalid for any reason, that provision shall be deemed null and void, but the invalidation of that provision shall not otherwise impair or affect the Plan or Benefit Feature.

Section 2.2. Definitions. In interpreting the Plan and any Benefit Feature under the Plan, the following rules of interpretation shall apply:

(a) "Administrator" means the University, as provided in Section 8.01. The Administrator shall serve as the plan administrator within the meaning of ERISA Section 3.

(b) "Appeal" means review by the Claims Supervisor of a Denial.

(c) "Benefit Feature" means one or more of the employee benefit components identified in the Schedules of Benefits to the Plan.

(d) "Child" means (i) an Eligible Employee's, Eligible Retiree's, Spouse's, or Domestic Partner's natural child, stepchild, or legally adopted child, (ii) a child who has been placed with an Eligible Employee, Eligible Retiree or Domestic Partner for adoption, or (iii) a child who has been placed with the Eligible Employee, Eligible Retiree or Domestic Partner by an authorized placement agency or by judgment, decree, or other order of a court of competent jurisdiction.

(e) "Claimant" means an individual who makes a claim for benefits under Article IX. For purposes of Article IX, references to a Claimant include a Claimant's authorized representative.

(f) "Claims Supervisor" means a person, firm, or company which has agreed to provide technical or administrative services and advice in connection with the operation of all or a part of a Benefit Feature, and perform such other functions, including processing and payment of claims, as may be delegated to it under such contract. The Administrator may review claims Appeals and, if applicable, coordinate External Reviews, as provided by the Benefit Feature.

(g) "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

(h) "Code" means the Internal Revenue Code of 1986, as amended from time to time.

(i) "Covered Person" means, with respect to any Benefit Feature, any Eligible Retiree or Dependent who is covered under that Benefit Feature and covered under the Plan.

(j) "Denial" means any of the following: a denial, reduction, termination, or failure to provide or make payment (in whole or in part) for a benefit, including determinations based on eligibility, and, with respect to health benefits, a denial, reduction, termination or failure to provide or make payment for a benefit based on utilization review or a failure to cover a benefit because it is determined to be experimental or investigational or not medically necessary.

(k) "Dependent" means:

(1) a Spouse;

(2) a Domestic Partner; and

(3) a Child until the end of the month in which the Child attains age twenty-six (26); provided, however, that a Child shall continue to be a Dependent after the end of the month in which the Child attains age twenty-six (26) if the Child is a Dependent under the Plan prior to attaining age twenty-six (26) and is permanently and totally disabled. A Child is permanently and totally disabled if the child is unable to engage in any substantial gainful activity due to a medically-determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of twelve (12) months or more. Proof of permanent and total disability must be provided to the Claims Supervisor prior to the Child's twenty-sixth (26th) birthday and proof of continued permanent and total disability may be required by the Claims Supervisor on an annual basis thereafter.

(l) "Domestic Partner" means, effective July 1, 2014, an individual of the same sex of an Eligible Retiree with respect to whom one of the following criteria have been satisfied:

(1) If the Eligible Retiree and the Domestic Partner reside in a state that recognizes a civil union or a substantially similar legal relationship, such Eligible Retiree and Domestic Partner have established such legal relationship under applicable state law and have submitted to the Plan the relevant certificate or other documentation of such legal relationship; or

(2) Regardless of the State in which the Eligible Retiree and Domestic Partner reside, such Eligible Retiree and Domestic Partner have satisfied the following requirements:

(A) are at least eighteen (18) years old and mentally competent to enter into contracts;

(B) reside together in the same principal residence and have done so for at least twelve (12) months prior to the effective date of the Affidavit of Domestic Partnership and intend to do so indefinitely;

(C) are emotionally committed to one another and share joint responsibilities for their common welfare and financial obligations and have done so for at least twelve (12) months prior to the effective date of the Affidavit of Domestic Partnership;

(D) are not legally married to nor the domestic partner of anyone else, nor have they been married to or the domestic partner of anyone else within the twelve (12) month period prior to the effective date of the Affidavit of Domestic Partnership;

(E) are not related by blood to an extent that would prohibit marriage in the state in which they reside; and

(F) sign, notarize and submit a completed Affidavit of Domestic

Partnership.

(m) "Electronic Protected Health Information" or "EPHI" means "electronic protected health information" as defined at 45 CFR § 160.103, which, generally, means Protected Health Information that is transmitted by, or maintained in, electronic media. For these purposes, "electronic media" means: (i) electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or (ii) transmission media used to exchange information already in electronic storage media (*e.g.*, the internet, extranet, leased lines, dial up lines, private networks, and the physical movement of removable/transportable electronic storage media).

(n) "Eligible Employee" means a common law employee of the University who is regularly scheduled to work at least thirty (30) hours per week (twenty-nine and one-half (29 ½) hours per week prior to July 1, 2014), but does not include: (A) leased employees as defined under Code Section 414(n); (B) any person who is providing services on a temporary basis or is designated to work only with respect to specific tasks or projects; (C) any individual who enters into an agreement with the University that they are not eligible for benefits; or (D) any individual designated in good faith by the University as an independent contractor (including, but not limited to, former employees of the University who have become employees of an unrelated employer and who continue to provide services to the University), regardless of whether the Internal Revenue Service or a court of law later determines such individual to be a common law employee for tax purposes.

(o) "Eligible Retiree" has the meaning set forth means:

(1) An Eligible Employee who (i) is age fifty five (55) or older, (ii) has at least fifteen (15) years of continuous full-time employment, (iii) has a combined age and years of continuous full-time employment that totals at least eighty (80), and (iv) was hired prior to January 1, 2013. Notwithstanding the preceding sentence, for an Eligible Employee who was hired prior to July 1, 1996, "Eligible Retiree" means an Eligible Employee who (i) is age sixty two (62) or older and (ii) has completed at least fifteen (15) years of continuous full-time employment.

(2) An Eligible Retiree shall also mean an Eligible Employee who (i) is age fifty five (55) or older, (ii) has at least five (5) years of continuous full-time employment; (iii) was hired prior to January 1, 2013; and (iv) is a Participant in the DePauw University Full-Insured Health Care Plan and Trust.

(p) "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

(q) "Health Care Operations" means "health care operations" as defined by 45 CFR § 164.501, as amended. Generally, Health Care Operations include, but are not limited to, the following activities taken by or on behalf of the Plan:

(1) Quality assessment;

(2) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(3) Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(4) Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

(5) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(6) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of Payment methods or coverage policies;

(7) Business management and general administrative activities of the Plan, including, but not limited to:

(A) Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or

(B) Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;

(C) Resolution of internal grievances;

(D) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, shall become a covered entity; and

(8) Any other activity considered to be a "health care operation" activity pursuant to 45 CFR § 164.501.

(r) "Health Care Professional" means a physician or other health care professional licensed, accredited, or certified to perform health services consistent with State law.

(s) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

(t) "Individual" means any person who is the subject of Protected Health Information.

(u) "Payment" means "payment" as defined by 45 § CFR 164.501, as amended. Generally, Payment activities include, but are not limited to, activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an Individual to whom health care is provided. These activities include, but are not limited to, the following:

(1) Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and copayments as determined for an Individual's claim);

(2) Coordination of benefits;

(3) Adjudication of health benefit claims (including Appeals and other payment disputes);

(4) Subrogation of health benefit claims;

(5) Establishing Eligible Retiree contributions;

(6) Risk adjusting amounts due based on an Eligible Retiree's health status and demographic characteristics;

(7) Billing, collection activities and related health care data processing;

(8) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to an Eligible Retiree's inquiries about payments;

(9) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(10) Medical necessity reviews or reviews of appropriateness of care or justification of charges;

(11) Utilization review, including precertification, preauthorization, concurrent review and retrospective review;

(12) Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following Protected Health Information may be disclosed for Payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan);

(13) Reimbursement to the Plan; and

(14) Any other activity considered to be a "payment" activity pursuant to 45 CFR § 164.501.

(v) "Plan" means the DePauw University Retiree Welfare Benefit Plan, as set forth in this document, as amended from time to time.

(w) "Plan Year" means the twelve (12) month period beginning on each January 1 and ending on each December 31.

(x) "Post-Service Claim" means any claim for a medical benefit that is not an Urgent Care Claim or a Pre-Service Claim.

(y) "Pre-Service Claim" means any claim for a medical benefit whereby the appropriate Benefit Feature under the Plan conditions receipt of such benefit, in whole or in part, on approval of the benefit prior to obtaining medical care.

(z) "Privacy Regulations" mean the regulations under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164, as amended).

(aa) "Protected Health Information" means "protected health information" as defined at 45 CFR § 164.501 which, generally, means information (including demographic information) that (i) identifies an Individual (or with respect to which there is a reasonable basis to believe the information can be used to identify an Individual), (ii) is created or received by a health care provider, a health plan, or a health care clearinghouse, and (iii) 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.

(bb) "Schedule of Benefits" means the Schedule A, Schedule B, or Schedule C as attached hereto and incorporated herein, and as amended from time to time.

(cc) "Section" means, when not preceded by the terms Code or ERISA, a section of the Plan.

(dd) "Security Incident" means "security incident" as defined at 45 CFR § 164.304, which, generally, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(ee) "Spouse" means, effective July 1, 2014, the person to whom an Eligible Retiree is married where the marriage was validly entered into in a state whose laws authorize the marriage, even if the Eligible Retiree is domiciled in a state that does not recognize the validity of the marriage.

(ff) "Summary Health Information" means "summary health information" as defined by 45 CFR § 164.504(a), as amended, which generally is information that may be individually identifiable health information, and:

(1) that summarizes the claims history, claims expenses, or type of claims experienced by Individuals for whom the University has provided health benefits under a group health plan; and

(2) from which the information described at § 164.514(b)(2)(i) of the Privacy Regulations has been deleted, except that the geographic information described in § 164.514(b)(2)(i)(B) of the Privacy Regulations need only be aggregated to the level of a five digit zip code.

(gg) "University " means DePauw University.

(hh) "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

Article III. _
BENEFITS

Section 3.1. Employee Benefits.

(a) The University shall provide the employee benefits set forth in the Schedule of Benefits to Eligible Retirees pursuant to the Plan. No Eligible Retiree or his or her Dependents shall have any vested interest in any Benefit Feature under the Plan.

(b) The fully insured Benefit Features provided through insurance companies or other benefit providers under the Plan are such benefits as are from time to time set forth in Schedule A, which is incorporated herein by reference and made a part hereof.

(c) The uninsured or partially insured Benefit Features provided under the Plan are such benefits as shall from time to time be set forth in Schedule B, which is incorporated herein by reference and made a part hereof.

Section 3.2. Insured Policies and Benefit Contracts Providing Employee Benefits.

(a) The University may, but is not obligated to, enter into insurance contracts issued by any insurance company qualified to do business in the United States or enter into contracts with any other benefit provider, including but not limited to any preferred provider organization ("PPO"), to provide benefits specified under Section 3.01. The University shall be the owner and policyholder of any such benefit contracts or policies. No Eligible Retiree or his or her Dependents shall have any vested interest in any Benefit Feature under the Plan.

(b) Any Benefit Feature set forth in Schedule A shall be limited to the benefits provided under any benefit contract or policy, as amended from time to time. Except as may be otherwise specifically provided in the Plan, the rights, duties, obligations, and responsibilities of the University, and the Eligible Retirees and their Dependents concerning the benefits shall be limited to such rights, duties, obligations, and responsibilities as may be set forth in any such benefit contract or policy, as amended from time to time.

(c) No benefit shall be paid or made available to any Eligible Retiree under Section 3.01(b), except as may be specifically provided by the University under Section 3.02(a).

Section 3.3. Uninsured Benefit Features.

(a) From time to time, the University may provide benefits which are not fully insured to Eligible Retirees, as set forth in Schedule B. In the event the University decides to provide such benefits, there shall be set forth in writing:

(1) the extent of such benefits, including periods during which benefits are provided;

(2) the procedures governing elections, if any, for such benefits;

(3) the eligibility requirements for such benefits;

(4) the University and Eligible Retiree contributions (when applicable) for such benefits or the formula for determining the same;

(5) the conditions and limitations on such benefits, including conditions precedent and subsequent with regard to qualification for benefits;

(6) the claims procedures; and

(7) such other matters as required pursuant to ERISA, the Code, or as the University in its sole discretion may deem relevant or appropriate.

Such writing shall be kept on file with the University and shall be made available to any Eligible Retiree upon written request. No Eligible Retiree or his or her Dependents shall have any vested interest in any Benefit Feature under the Plan.

(b) No benefit shall be paid or made available to any Eligible Retiree under Section 3.01(c), except as may be specifically provided by the University under Section 3.03(a).

Section 3.4. **Incorporation of All Relevant Benefit Feature Documents**. All written documents relating to the Benefit Features are set forth in the Plan and the attached Schedule C, which documents are incorporated herein by reference and made a part hereof.

Section 3.5. **Termination, Addition, and Modification of Benefit Features**.

(a) The University may terminate any Benefit Feature from the Plan by amending Schedule A or Schedule B of the Plan and deleting such terminated benefit therefrom, which revised Schedule A or Schedule B shall become a part hereof.

(b) The University may add to or modify any Benefit Feature under the Plan, by adopting a revised Schedule A or Schedule B, as the case may be, and adding such additional benefit or modification thereto, which revised Schedule A or Schedule B shall become a part hereof. The University may make appropriate modifications to such schedules without the need for Plan amendment. Any such additional benefit shall be subject to all of the terms and conditions of the Plan.

Article IV. __ CONTINUATION OF COVERAGE

Section 4.1. Election Between COBRA and Retiree Coverage.

(a) Upon retirement from the University, an Eligible Retiree shall be given the opportunity to make an election to:

(1) if the Eligible Retiree is under age sixty-five (65) and/or if the Eligible Retiree's Spouse or Domestic Partner is under age sixty-five (65), the Eligible Retiree may elect, for himself or herself and his or her under age sixty-five (65) Dependents, coverage under the retiree medical, dental and/or vision plan under the DePauw University Welfare Benefit Plan; or

(2) if the Eligible Retiree is age sixty-five (65) or older and/or if the Eligible Retiree's Spouse or Domestic Partner is age sixty-five (65) or older, the Eligible Retiree may elect, for himself or herself and his or her Spouse or Domestic Partner who is sixty-five (65) or older, coverage under the medical and dental Benefit Feature under this Plan (the Eligible Retiree must elect coverage under the medical Benefit Feature in order to participate in the dental Benefit Feature); or

(3) the Eligible Retiree may elect to continue coverage for himself or herself and his or her Dependents under the medical, dental and/or vision plan under the DePauw University Welfare Benefit Plan pursuant to COBRA.

(b) An election under subparagraph (1) or (2) above must be made within sixty (60) days of the date of the Eligible Retiree's retirement and shall be in lieu of COBRA continuation coverage under the medical, dental and/or vision plan under the DePauw University Welfare Benefit Plan. If an Eligible Retiree does not make an election under subparagraph (1) or (2) above within this sixty (60) day period, the Eligible Retiree shall be deemed to have waived all rights to such retiree medical, dental and/or vision coverage on behalf of himself or herself and his or her Dependents; provided, however, that the preceding paragraph shall not apply if the Eligible Retiree (i) declines retiree medical, dental and/or vision coverage under subparagraph (1) or (2) above because the Eligible Retiree is enrolled in other employer provided group health plan coverage and (ii) the Eligible Retiree makes an election to enroll in retiree medical, dental and/or vision coverage under subparagraph (1) or (2) above within sixty (60) days after the loss of such other employer provided group health plan coverage (for any reason other than failure to timely pay the premiums for such other coverage).

(c) An Eligible Retiree who is under sixty-five (65) but whose Spouse or Domestic Partner is sixty-five (65) or older may enroll his or her Spouse or Domestic Partner in retiree medical and dental coverage under subparagraph (2) of paragraph (a), but only if the Eligible Retiree enrolls himself or herself in retiree medical coverage under subparagraph (1) of paragraph (a). An Eligible Retiree who is sixty-five (65) or older and whose Spouse or Domestic Partner and/or Dependent Children are under sixty-five (65) may enroll his or her Spouse or Domestic Partner and/or Dependent Children in retiree medical, dental and/or vision coverage under subparagraph (1) of paragraph (a), but only if the Eligible Retiree enrolls himself or herself in retiree medical coverage under subparagraph (2) of paragraph (a).

(d) If an Eligible Retiree enrolls himself or herself and/or his or her Spouse or Domestic Partner in retiree medical, dental and/or vision coverage under subparagraph (1) of paragraph (a), and then the Eligible Retiree and/or Spouse or Domestic Partner subsequently attains age sixty-five (65), then the Eligible Retiree must enroll himself or herself or his or her Spouse or Domestic Partner, as applicable, in the medical and dental Benefit Feature under the Plan within sixty (60) days after attaining age sixty-five (65). If an Eligible Retiree does not make such an election within this sixty (60) day period, the Eligible Retiree shall be deemed to have waived all rights to such retiree medical and dental coverage on behalf of himself or herself and his or her Dependents.

(e) An Eligible Retiree and/or his or her Spouse or Domestic Partner must meet the following criteria to be eligible for the medical Benefit Feature under this Plan: (i) be eligible for Medicare; (ii) be enrolled in both Medicare Parts A and B; (iii) have no Medicare supplement coverage; and (iv) be age sixty-five (65) or older.

(f) Only the Eligible Retiree's Spouse or Domestic Partner and/or Dependent Children at the time of the Eligible Retiree's termination of employment may enroll in retiree medical, dental and/or vision coverage under subparagraph (1) or (2) of paragraph (a); provided, however, that special enrollment rights shall apply to the extent legally required with respect to retiree coverage under subparagraph (1) of paragraph (a).

(g) If an Eligible Retiree dies before or after commencing retiree medical, dental and/or vision coverage under subparagraph (1) or (2) of paragraph (a), his or her surviving Spouse or Domestic Partner may elect or continue retiree coverage, as applicable, for himself or herself and any Dependent Children; provided that if the Eligible Retiree dies before commencing retiree medical, dental and/or vision coverage, the Spouse or Domestic Partner makes the required election under subparagraph (1) or (2) of paragraph (a) within sixty (60) days of the Eligible Retiree's death.

Section 4.2. Applicability. The Benefit Features under the Plan shall comply with all requirements under COBRA to the extent applicable, as described in this Article. When a Eligible Retiree's coverage ends under this Plan, there is no continuation coverage for the Eligible Retiree. In some circumstances, continuation coverage under the Plan may be available to a Eligible Retiree's Spouse or Domestic Partner, as provided below. Continuation coverage to a Domestic Partner is not legally required under COBRA, but the Benefit Features under the Plan voluntarily extend such coverage to Domestic Partners.

Section 4.3. Right to Continuation Coverage. A Qualified Beneficiary may elect to continue group health coverage under the Plan in accordance with the applicable Benefit Feature after a Qualifying Event. Only those individuals who are covered under the group health coverage under the applicable Benefit Feature on the day before the event which triggered termination of coverage are eligible to elect this continuation coverage.

Section 4.4. Qualified Beneficiary. Only Qualified Beneficiaries may elect continuation coverage under the group health coverage under the applicable Benefit Feature. For purposes of this Article, a "Qualified Beneficiary" is a person covered under the group health coverage under the applicable Benefit Feature on the day before a Qualifying Event who is a Spouse or Domestic

Partner of a covered Eligible Retiree.

Section 4.5. Qualifying Events. The right to continued coverage is triggered by one of the Qualifying Events as set forth below, which, but for the continued coverage, would result in a loss of coverage under the group health coverage under the applicable Benefit Feature. A "loss of coverage" includes ceasing to be covered under the same terms and conditions as in effect immediately before the Qualifying Event or an increase in the premium or contribution that must be paid by a covered person. Qualifying Events include:

(a) the death of the covered Eligible Retiree;

(b) the divorce or legal separation of the covered Eligible Retiree from the covered Eligible Retiree's Spouse; or

(c) the dissolution of the domestic partnership of the covered Eligible Retiree from the covered Eligible Retiree's Domestic Partner.

If any of the above-mentioned Qualifying Events occur to a Qualified Beneficiary, then that Qualified Beneficiary may elect to continue coverage under the group health coverage under the applicable Benefit Feature.

Section 4.6. Election of Continuation Coverage. Continuation coverage does not begin unless it is elected by a Qualified Beneficiary. Each Qualified Beneficiary who loses coverage as a result of a Qualifying Event shall have an independent right to elect continuation coverage, regardless of whether any other Qualified Beneficiary with respect to the same Qualifying Event elects continuation coverage. The election period shall begin not later than the date the Qualified Beneficiary would lose coverage under the group health coverage under the applicable Benefit Feature due to the Qualifying Event, and shall not end before the date that is sixty (60) days after the later of: (i) the date the Qualified Beneficiary would lose coverage due to the Qualifying Event, or (ii) the date on which notice of the right to continued coverage is sent by the Administrator or its designee. The election of continuation coverage must be made on a form provided by the Administrator or its designee and payment for coverage, as described in the notice, must be made when due. An election is considered to be made on the date it is sent to the Administrator or its designee.

Section 4.7. Period of Continuation Coverage. In the case of any Qualifying Event described above, the Qualified Beneficiary may elect to extend coverage for a period of up to thirty-six (36) months from the date of the Qualifying Event, unless it ends earlier as described under Section 4.08.

Section 4.8. End of Continuation Coverage. Continuation coverage shall end earlier than the period specified under Section 4.07:

(a) as of the first day (including any grace period) for which timely payment of premiums for the continuation coverage is not made;

(b) if the Qualified Beneficiary first becomes covered under any other group health plan, after the date on which continuation coverage is elected, as an employee or otherwise, unless

such other plan contains a limitation (other than a limitation which does not apply by virtue of HIPAA) with respect to any pre-existing condition of the Qualified Beneficiary; or

(c) if the University ceases to provide any group health plan to any employee or Eligible Retiree;

(d) the period of continuation coverage expires as set forth in Section 4.07.

Notwithstanding the foregoing, the Plan may also terminate the continuation coverage of a Qualified Beneficiary for cause on the same basis that the Plan could terminate the coverage of a similarly situated non-COBRA beneficiary for cause (*e.g.*, in the case of submitting fraudulent claims to the Plan).

Section 4.9. **Cost of Continuation Coverage**. The Qualified Beneficiary is responsible for paying the cost of continuation coverage, hereinafter referred to as "premium." The premiums are payable on a monthly basis, and shall be in amounts equal to one hundred two percent (102%) of the full premium cost for such coverage (or one hundred fifty percent (150%) in the event of a disability). After a Qualifying Event, the Administrator (or its designee) shall provide a notice specifying the amount of the premium, to whom the premium is to be paid, and the date of each month payment is due. Failure to pay premiums on a timely basis shall result in termination of coverage as of the date the premium is due. Payment of any premium, other than that referred to below, shall only be considered to be timely if made within thirty (30) days after the date due. A premium must be paid for the cost of continuation coverage for the time period between the date of the event which triggered continuation coverage and the date continued coverage is elected. This payment must be made within forty-five (45) days after the date of election. The Administrator (or its designee) shall provide notice specifying the amount of the premium, to whom the premium is to be paid, and the date payment is due. Failure to pay this premium on the date due shall result in cancellation of coverage back to the initial date coverage would have terminated.

Section 4.10. **Notification Requirements**.

(a) General Notice to Eligible Retiree and Spouse or Domestic Partner. The group health coverage under the applicable Benefit Feature shall provide, at the time of commencement of coverage, written notice to each covered Eligible Retiree and to the Spouse or Domestic Partner of the covered Eligible Retiree (if any) of their rights to continuation coverage. The Plan may satisfy this obligation by furnishing a single notice addressed to both a covered Eligible Retiree and the covered Eligible Retiree's Spouse or Domestic Partner if they both reside at the covered Eligible Retiree's address, and the Spouse's or Domestic Partner's coverage commences on or after the date on which the covered Eligible Retiree's coverage commences, but not later than the date by which this general notice must be provided under this subparagraph (a). This general notice shall be provided not later than the earlier of: (i) ninety (90) days after such individual's coverage commencement date under the Plan or (ii) the date on which the Administrator is required to furnish a COBRA election notice as described in subparagraph (d) of this Section.

(b) University Notice to Administrator. The University shall notify the Administrator or its designee in the event of a covered Eligible Retiree's death within thirty (30) days after the date of the Qualifying Event.

(c) Eligible Retiree/Qualified Beneficiary Notice to Administrator. The covered Eligible Retiree or Qualified Beneficiary must notify the Administrator or its designee of a (i) divorce or legal separation of the covered Eligible Retiree from the covered Eligible Retiree's Spouse or (ii) dissolution of the domestic partnership of the covered Eligible Retiree from the covered Eligible Retiree's Domestic Partner. Notification must occur as soon as possible, but not later than sixty (60) days after the later of: (i) the date of such Qualifying Event; (ii) the date that the Qualified Beneficiary loses or would lose coverage due to such Qualifying Event; or (iii) the date on which the Qualified Beneficiary is informed, via the Plan's summary plan description or the general COBRA notice, of the Qualified Beneficiary's obligation to provide such notice and the Plan procedures for providing such notice.

The covered Eligible Retiree, Qualified Beneficiary, or a representative acting on behalf of the covered Eligible Retiree or Qualified Beneficiary, may provide such notice. The provisions of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event. Failure to provide such timely notice shall result in the loss of any right to elect continuation coverage.

The group health plan under the applicable Benefit Feature shall establish reasonable procedures for the furnishing of the notice described above that comply with 29 CFR Section 2590.606-3 and shall publish such procedures in the applicable plan's Summary Plan Description. A Qualified Beneficiary's failure to follow such procedures within the times prescribed above shall result in a denial of continuation coverage.

(d) Administrator Notice to Qualified Beneficiary. Upon receipt of a notice of Qualifying Event under Section 4.10(a) or (b), the Administrator or its designee shall provide to each Qualified Beneficiary notice of their right to elect continuation coverage, no later than fourteen (14) days after the date on which the Administrator or its designee received notice of these Qualifying Events.

(e) Unavailability of Coverage. If the Administrator or its designee receives a notice of a Qualifying Event under Section 4.10(b) and determines that the person is not entitled to continuation coverage, the Administrator or its designee shall notify the person with an explanation as to why such coverage is not available within the time frame designated under Section 4.10(c) above.

(f) Notice of Termination of Coverage. The Administrator or its designee shall provide notice to each Qualified Beneficiary of any termination of continuation coverage which is effective earlier than the end of the maximum period of continuation coverage applicable to such Qualifying Event, as soon as practicable following the Administrator's determination that continuation coverage should terminate.

(g) Use of a Single Notice. Notices required under Section 4.10(d), (e), and (f) must be provided to each Qualified Beneficiary or individual; however, a single notice can be provided to

the covered Eligible Retiree and the covered Eligible Retiree's Spouse or Domestic Partner if the covered Eligible Retiree's Spouse or Domestic Partner resides with the covered Eligible Retiree.

Section 4.11. Continuation Health Benefits Provided. The continuation coverage provided to a Qualified Beneficiary who elects continued coverage shall be identical to the coverage provided under the group health coverage to similarly situated persons covered by the group health coverage with respect to whom a Qualifying Event has not occurred. If coverage is modified under the group health coverage for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are Qualified Beneficiaries under the group health coverage. Continuation coverage may not be conditioned on evidence of good health.

If the group health plan coverage under the applicable Benefit Feature provides an open enrollment period during which similarly situated active employees may choose to be covered under another group health plan or under another benefit package within the group health plan coverage under the applicable Benefit Feature, or to add or eliminate coverage of family members, the group health plan coverage under the applicable Benefit Feature shall provide the same opportunity to Qualified Beneficiaries who have elected continuation coverage.

Section 4.12. Bankruptcy Proceedings. Special continuation coverage provisions apply in the event of bankruptcy of the University. Notwithstanding any of the preceding Sections, in the event of a bankruptcy proceeding under Title XI of the United States Code, where a loss of coverage or substantial elimination of coverage occurs with respect to a covered Eligible Retiree who had retired on or before the date of the loss or substantial elimination of coverage (and any other individual who, on the day before the bankruptcy proceeding, is a beneficiary under the applicable Benefit Feature as a Spouse, Domestic Partner, Dependent Child, or surviving Spouse of a covered Eligible Retiree) within one year before or after the date of the commencement of the bankruptcy proceeding, continuation coverage shall be provided under the group health coverage under the applicable Benefit Feature to the extent required under ERISA Sections 602 through 607 and Code Section 4980(B).

Article V.
LAWS AFFECTING BENEFIT FEATURES

Section 5.1. Health Insurance Portability and Accountability Act of 1996. Any group health plan, as that term is defined in HIPAA, which is incorporated into this Plan as a Benefit Feature and which is obligated to meet the requirements of HIPAA (hereinafter referred to in this Article as "affected Benefit Feature") shall comply with HIPAA, as amended from time to time, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing such Benefit Feature.

Section 5.2. Genetic Information Nondiscrimination Act of 2008. Effective January 1, 2010, the Plan and any applicable affected Benefit Feature shall comply with the Genetic Information Nondiscrimination Act of 2008, as amended, and any regulations issued thereunder, to the extent required thereunder, and to the extent not inconsistent with any federal law or regulations governing the Plan or any Benefit Feature. As part of such compliance, neither the Plan nor any applicable Benefit Feature may adjust premiums or contribution amounts for the

group covered under the Plan or affected Benefit Feature on the basis of genetic information, and shall not request or require an individual or family member of such individual to undergo a genetic test unless the research exception under Code Section 9802(c)(4) is satisfied. The Plan shall not request, require, or purchase genetic information for underwriting purposes or with respect to any individual prior to such individual's enrollment under the Plan or affected Benefit Feature, or in connection with such enrollment.

Section 5.3. **Newborns' and Mothers' Health Protection Act of 1996**. Any group health plan, as that term is defined in HIPAA, which is incorporated into this Plan as a Benefit Feature and which is obligated to meet the requirements of the Newborns' and Mothers' Health Protection Act of 1996 shall comply with the Newborns' and Mothers' Health Protection Act of 1996, as amended from time to time, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing such Benefit Feature. As part of such compliance, no affected Benefit Feature, or health insurance funding such affected Benefit Feature, may restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following normal vaginal delivery, or less than ninety-six (96) hours following a caesarean section, or require that a provider obtain authorization from the Plan, affected Benefit Feature, or insurance issuer for prescribing a length of stay not in excess of the above periods.

Section 5.4. **Uniformed Services Employment and Reemployment Rights Act of 1994**. Any group health plan which is a part of this Plan as a Benefit Feature, which is obligated to meet the requirements of USERRA shall comply with the USERRA, as amended from time to time, and any regulations issued thereunder, and to the extent not otherwise inconsistent with any federal law or regulation governing such Benefit Feature.

Article VI.
PROTECTED HEALTH INFORMATION

Section 6.1. **Adoption and Effective Date**. This Article is adopted to reflect certain provisions of HIPAA. It is intended as good faith compliance with the requirements of HIPAA and is to be construed in accordance with HIPAA and guidance issued thereunder. A Benefit Feature under the Plan shall comply with all requirements under this Article to the extent applicable, as described below.

Section 6.2. **Supersession of Inconsistent Provisions**. This Article shall supersede the provisions of the Plan to the extent those provisions are inconsistent with the provisions of this Article.

Section 6.3. **Use and Disclosure of Protected Health Information**. The Plan shall use and disclose Protected Health Information to the extent of and in accordance with the uses and disclosures permitted by HIPAA, as set forth in the Privacy Regulations. Specifically, the Plan shall use and disclose Protected Health Information for purposes related to health care treatment, Payment for health care, and Health Care Operations.

Section 6.4. <u>Plan Documents</u>. In order for the Plan to disclose Protected Health Information to the University or to provide for or permit the disclosure of Protected Health Information to the University by a health insurance issuer with respect to the Plan, the Plan must ensure that the Plan documents restrict uses and disclosures of such information by the University consistent with the requirements of HIPAA.

Section 6.5. <u>Disclosures by Plan to the University</u>. The Plan may:

(a) Disclose Summary Health Information to the University, if the University requests the Summary Health Information for the purpose of:

(1) Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

(2) Modifying, amending, or terminating the Plan.

(b) Disclose to the University information on whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer offered by the Plan.

(c) Disclose Protected Health Information to the University to carry out Plan administration functions that the University performs, consistent with the provisions of Section 6.06 to Section 6.08 of this Article;

(d) With an authorization from the Eligible Retiree, disclose Protected Health Information to the University for purposes related to the administration of other employee benefit plans and fringe benefits sponsored by the University.

(e) Not permit a health insurance issuer with respect to the Plan to disclose Protected Health Information to the University except as permitted by this Section.

(f) Not disclose (and may not permit a health insurance issuer to disclose) Protected Health Information to the University as otherwise permitted by this Section unless a statement is included in the Plan's notice of privacy practices that the Plan (or a health insurance issuer with respect to the Plan) may disclose Protected Health Information to the University.

(g) Not disclose Protected Health Information to the University for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the University.

Section 6.6. <u>Uses and Disclosures by the University</u>. The University may only use and disclose Protected Health Information as permitted and required by the Plan, as set forth within this Article. Such permitted and required uses and disclosures may not be inconsistent with the provisions of HIPAA. The University may use and disclose Protected Health Information without an authorization from an Eligible Retiree for Plan administrative functions including Payment activities and Health Care Operations. In addition, the University may also use and disclose Protected Health Information to accomplish the purpose for which any disclosure is properly made pursuant to Section 6.05.

Section 6.7. Certification. The Plan may disclose Protected Health Information to the University only upon receipt of a certification from the University that the Plan documents have been amended to incorporate the provisions provided for this Section 6.07 and that the University so agrees to the provisions set forth therein.

Section 6.8. Conditions Agreed to by the University. The University agrees to:

(a) Not use or further disclose Protected Health Information other than as permitted or required by the Plan document or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom the University provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the University with respect to such Protected Health Information, and that any such agents or subcontractors agree to implement reasonable and appropriate security measures to protect any Electronic Protected Information belonging to the Plan that is provided by the University;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions unless authorized by an Individual;

(d) Not use or disclose Protected Health Information in connection with any other benefit or employee benefit plan of the University unless authorized by an Individual;

(e) Report to the Plan any Protected Health Information use or disclosure that is inconsistent with the uses or disclosures provided for by this Article, or any Security Incident of which it becomes aware;

(f) Make Protected Health Information available to an Individual in accordance with HIPAA's access requirements pursuant to 45 CFR § 164.524;

(g) Make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR § 164.526;

(h) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

(i) Make internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA;

(j) If feasible, return or destroy all Protected Health Information received from the Plan that the University still maintains in any form, and retain no copies of such Protected Health Information when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible);

(k) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates receives, maintains, or transmits on behalf of the Plan; and

(l) Ensure that the separation and requirements of Section 6.09, Section 6.10, and Section 6.11 of the Plan are supported by reasonable and appropriate security measures.

Section 6.9. **Adequate Separation Between the Plan and the University**. In accordance with HIPAA, only the designated Privacy Officer and those individuals identified in the HIPAA Policies and Procedures who have a need for Protected Health Information to help administer the Plan may be given access to Protected Health Information.

Section 6.10. **Limitations of Access and Disclosure**. The persons described in Section 6.09 of this Article may only have access to and use and disclose Protected Health Information for Plan administration functions that the University performs for the Plan.

Section 6.11. **Noncompliance**. If the persons or classes of persons described in Section 6.09 of this Article do not comply with this Plan document, the Plan and the University shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Article VII.
FUNDING POLICY AND CONTRIBUTIONS TO THE PLAN

The University shall be responsible for establishing and carrying out the funding policy of the Plan for the provisions of benefits consistent with the objectives of the Plan. Certain uninsured Benefit Features adopted by the University may be paid from the general assets of the University. Contributions to provide fully insured benefits or self-insured benefits under the Plan shall be paid to the appropriate insurance company or benefit provider pursuant to the applicable Benefit Feature. All Benefit Feature contributions may consist of University contributions or Eligible Retiree contributions, as applicable. The University shall determine the amount, if any, of contributions to be made by each Eligible Retiree with respect to each Benefit Feature. Eligible Retiree contributions for Benefit Features shall be communicated to Eligible Retirees.

Article VIII.
ADMINISTRATION OF THE PLAN

Section 8.1. **Administrator.** The University shall be the Administrator of the Plan within the meaning of ERISA; provided, however, the Administrator may from time to time designate a person, subcommittee, Claims Supervisor, or organization to perform certain responsibilities of the Administrator. Any such individual, subcommittee, or organization shall perform the delegated functions until removal by the Administrator, which removal may be without cause and without advance notice. Except as otherwise specifically provided in the Plan, the Administrator shall have full, discretionary authority to control and manage the operation and administration of the Plan, and shall be named fiduciary of the Plan. The Administrator shall have all power necessary or convenient to enable the Administrator to exercise such authority. The Administrator or its designee may provide rules and regulations, not inconsistent with the

provisions hereof, for the operation and management of the Plan, and may from time to time amend or rescind such rules or regulations. The Administrator shall have the full discretion, power, and the duty to take all action necessary or proper to carry out the duties required under ERISA. The Administrator is authorized to accept service of legal process for the Plan.

Section 8.2. Claims Supervisor. The University may appoint or remove a Claims Supervisor with respect to any or all of the Benefit Features under the Plan.

Section 8.3. Discretionary Authority of Administrator.

(a) The Administrator shall have full, discretionary authority to enable it to carry out its duties under the Plan, including but not limited to, the authority to determine eligibility under the Plan and to construe and interpret the terms of the Plan and to determine all questions of fact or law arising hereunder. All such determinations and interpretations shall be final, conclusive, and binding on all persons affected thereby. The Administrator shall have full, discretionary authority to correct any defect, supply any omission or reconcile any inconsistency and resolve ambiguities in the Plan in such manner and to such extent as they may deem expedient, and the Administrator shall be the sole and final judge of such expediency. Benefits under this Plan will be paid only if the Administrator decides, in its discretion, that the applicant is entitled to them.

(b) The Administrator shall have full, discretionary authority to control and manage the operation and administration of the Plan, and shall be the named fiduciary of the Plan. The Administrator shall have all power necessary or convenient to enable the Administrator to exercise such authority. The Administrator or its designee may provide rules and regulations, not inconsistent with the provisions hereof, for the operation and management of the Plan, and may from time to time amend or rescind such rules or regulations. The Administrator shall have the full discretion, power, and the duty to take all action necessary or proper to carry out the duties required under ERISA. The Administrator is authorized to accept service of legal process for the Plan.

Section 8.4. Provision for Third-Party Administrative Service Providers. The Administrator may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan and may delegate to such persons any duty assigned to the Administrator hereunder.

Section 8.5. Timeliness of Benefit Payments. Payments shall be made as soon as administratively feasible after the required forms and documentation have been received by the Administrator, subject to the Claims Procedure requirements set out in Article IX.

Section 8.6. Designation of Fiduciaries. The Administrator may designate another person or persons to carry out any fiduciary responsibility of the Administrator under the Plan. The Administrator shall not be liable for any act or omission of such person in carrying out such responsibility, except as may be otherwise provided under ERISA. To the extent permitted under ERISA, no fiduciary of the Plan shall be liable for any act or omission in carrying out the fiduciary's responsibilities under the Plan. To the extent permitted under ERISA, each fiduciary under the Plan shall be responsible only for the specific duties assigned under the Plan and shall not be directly or indirectly responsible for the duties assigned to another fiduciary.

Article IX. _
CLAIMS PROCEDURES

Section 9.1. Coordination of Claims Procedures. The following procedures shall apply only (i) to the extent that the Benefit Feature has no claims provisions and is subject to the requirements under ERISA Section 503 or (ii) to the extent that the claim procedures of the Benefit Feature do not comply with the requirements under ERISA Section 503 but such compliance is legally required. Subject to the preceding sentence, Section 9.02 shall apply to health claims, Section 9.03 shall apply to claims for all other welfare plans subject to the requirements of ERISA Section 503, and Section 9.04 shall apply to all claims for benefits, unless otherwise noted. All notifications by any Claims Supervisor to a Claimant for claim review, Denial, approval and Appeal (see Sections 9.02 through 9.04) may be done in writing or electronically, unless otherwise designated.

Section 9.2. Claims for Health Benefits.

(a) Initial Claim for Health Benefits. Any claim to receive health benefits under the appropriate Benefit Feature under the Plan must be filed with the Claims Supervisor within the designated time period on the designated form, and will be deemed filed upon receipt. If a Claimant fails to follow the claims procedures outlined herein for filing an Urgent Care Claim or a Pre-Service Claim, the Claimant will be notified orally (unless the Claimant requests written notice) of the proper procedures to follow, not later than twenty-four (24) hours for Urgent Care Claims and five (5) days for Pre-Service Claims. This special timing rule applies only to Urgent Care Claims and Pre-Service Claims that: (1) are received by the person or unit customarily responsible for handling benefit matters; and (2) specify a Claimant, a medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Claimant must submit any required physician statements on the appropriate form (as required under the applicable health Benefit Feature). If the Claims Supervisor disagrees with the physician statement, the terms of the applicable health Benefit Feature will be followed in resolving any such dispute.

(b) Initial Review of Health Benefit Claims. When a claim for health benefits has been properly filed, the Claimant will be notified of the approval or Denial within the time periods set forth in the chart in subsection (i) below.

(c) Initial Denial of Health Benefit Claims. If any claim for health benefits is partially or wholly Denied, the Claimant will be given notice which will contain the following items:

(1) the specific reasons for the Denial;

(2) references to applicable Benefit Feature provisions upon which the Denial is based;

(3) a description of any additional material or information needed and why such material or information is necessary;

(4) a description of the review procedures and time limits, including information regarding how to initiate an Appeal, and a statement of the Claimant's right to bring civil action under ERISA Section 502(a) following a Denial on Appeal;

(5) the specific internal rule, guideline, protocol, or other similar criterion, if any, relied upon in making the Denial, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon, with a copy free of charge upon request;

(6) if the Denial 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 or a statement that such explanation will be provided free of charge upon request; and

(7) for Urgent Care Claims, a description of the expedited review process applicable to such claims.

For Urgent Care Claims, the information in the notice may be provided orally if the Claimant is given notification within three (3) days after the oral notification.

(d) First Level Appeal of Health Benefit Claim Denial. A Claimant may initiate a first level of Appeal of the Denial of a health claim by filing a written claim Appeal with the Claims Supervisor within the time period set forth in the chart in subsection (i) below, which will be deemed filed upon receipt. If the request is not timely, the decision of the Claims Supervisor will be the final decision of the applicable Benefit Feature, and will be final, conclusive, and binding on all persons. For Urgent Care Claims, a Claimant may make a request for an expedited Appeal orally or in writing, and all necessary information will be transmitted by telephone, facsimile, or other similarly expeditious method.

(e) Decision on First Level Appeal of Health Benefit Claim Denial.

(1) The Claimant will receive notice of the Claims Supervisor's decision on the first level of Appeal within the time periods shown in subsection (i) below. If the claim for benefits under the medical Benefit Feature is Denied on Appeal, the Claims Supervisor will provide notice to the Claimant containing the information set forth in subparagraph (3) of this subsection (e). The decision on Appeal will be final, conclusive, and binding on all persons.

(2) With respect to claims for benefits under the medical Benefit Feature, the Claims Supervisor will provide the Claimant with the following information free of charge as soon as possible and sufficiently in advance of the date on which the notice of Denial is required under subsection (i) below, such that the Claimant has a reasonable opportunity to respond prior to that date: (A) any new or additional evidence considered, relied upon, or generated by the Claims Supervisor (or at the direction of the Claims Supervisor) in connection with the claim, and (B) any new or additional rationale that forms the basis of the Claims Supervisor's Denial, if any.

(3) In addition, if the health claim is denied on Appeal, the Claimant will be given notice with a statement that the Claimant is entitled to receive, free of charge, access to

and copies of all documents, records, and other information that apply to the claim. The notice will also contain:

(A) the specific reasons for the Denial;

(B) references to applicable Benefit Feature provisions upon which the Denial is based;

(C) a description of the review procedures and time limits, including information regarding how to initiate an Appeal and a statement of the Claimant's right to bring civil action under ERISA Section 502(a) following a Denial on Appeal;

(D) the specific internal rule, guideline, protocol, or other similar criterion, if any, relied upon in making the Denial, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon, with a copy free of charge upon request; and

(E) if the Denial 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 or a statement that such explanation will be provided free of charge upon request.

Unless the Benefit Feature provides a second level of appeal, the decision on review will be final, conclusive, and binding on all persons.

(f) Second Level Appeal of Health Benefit Claim Denial. If permitted under the Benefit Feature, a Claimant may initiate a second level of Appeal of the Denial of a health claim by filing a written claim Appeal with the Administrator within the time period set forth in subsection (i) below, which will be deemed filed upon receipt. If the Claimant does not file a timely second level of Appeal, the decision on the first level of Appeal shall be final, conclusive, and binding on all persons.

(g) Decision on Second Level of Appeal of Health Benefit Claim Denial. The Administrator or its designee shall provide the Claimant with notice of its decision on the second level of Appeal within the time periods shown in subsection (i) below. If the claim is denied on the second level of Appeal, the Administrator or its designee shall provide notice to the Claimant containing the information set forth in Section 11.03(e)(3). The decision on the second level of Appeal shall be final, conclusive, and binding on all persons.

(h) Ongoing Treatments. If the Claims Supervisor or Administrator, as appropriate, under the Plan has approved an ongoing course of treatment to be provided to a Claimant over a certain period of time or for a certain number of treatments, any reduction or termination under of such course of treatment before the approved period of time or number of treatments end will constitute a Denial. The Claimant will be notified of the Denial, in accordance with Section 9.03(c), before the reduction or termination occurs to allow the Claimant a reasonable time to file an Appeal and obtain a determination on the Appeal. With respect to Appeals for benefits under the medical Benefit Feature, coverage for the ongoing course of treatment that is the subject of

the Appeal will continue pending the outcome of such Appeal.

For an Urgent Care Claim, any request by a Claimant to extend the ongoing treatment beyond the previously approved period of time or number of treatments will be decided no later than twenty-four (24) hours after receipt of the Urgent Care Claim, provided the claim is filed at least twenty-four (24) hours before the treatment expires.

(i) Chart of Time Limits for Health Benefit Claims.

	MAXIMUM TIME LIMITS FOR:							
TYPE OF CLAIM	**Claims Supervisor to decide initial claim (if no additional information is needed) (whether adverse or not)**	**Extension of time by Plan for determining initial claim**	**Claims Supervisor to notify Claimant of information needed from Claimant to decide initial claim, if not provided by Claimant**	**Claims Supervisor to notify Claimant of Claimant's failure to follow proper procedures**	**Claimant to then provide needed information (if extension allowed by Plan)**	**Claims Supervisor to decide claim after requesting additional information and notifying Claimant (if applicable)**	**Claimant to file Appeal**	**Claims Supervisor to decide Appeal**
Urgent Care Claims	No later than 72 hours after receipt of the claim by the Claims Supervisor	None	No later than 24 hours after receipt of incomplete claim by Claims Supervisor	No later than 24 hours after receipt of improper claim by Claims Supervisor	Not less than 48 hours after receipt of notice from Claims Supervisor	No later than 48 hours after earlier of (i) Claims Supervisor 's receipt of additional information from Claimant, or (ii) end of time period given to Claimant to provide additional information (48 hours)	180 days after receipt of Denial by Claimant If second level of appeal applies – claimant to have reasonable opportunity to pursue second appeal	72 hours after Claim Supervisor's receipt of appeal from claimant
Pre-Service Claims	No later than 15 days after receipt of claim by the Claims Supervisor	One time 15-day extension allowed if (i) due to matters beyond Claims Supervisor's control and (ii) Claims Supervisor notifies Claimant before end of initial 15-day time period of the circumstances requiring such extension and the date Claims Supervisor expects to render decision. If extension is due to Claimant's failure to submit information, notice will describe required	N/A	No later than 5 days after receipt of improper claim by Claims Supervisor	At least 45 days after receipt of notice from Claims Supervisor *Note*: Claims Supervisor may or may not request needed information from Claimant.	No later than 15 days after earlier of (i) Claims Supervisor 's receipt of additional information from Claimant, if requested, or (ii) end of time period given to Claimant to provide additional information (45 days)	180 days after receipt of Denial by Claimant If second level of appeal applies – claimant to have reasonable opportunity to pursue second appeal	30 days after Claim Supervisor's receipt of appeal from claimant

TYPE OF CLAIM	MAXIMUM TIME LIMITS FOR: Claims Supervisor to decide initial claim (if no additional information is needed) (whether adverse or not)	Extension of time by Plan for determining initial claim	Claims Supervisor to notify Claimant of information needed from Claimant to decide initial claim, if not provided by Claimant	Claims Supervisor to notify Claimant of Claimant's failure to follow proper procedures	Claimant to then provide needed information (if extension allowed by Plan)	Claims Supervisor to decide claim after requesting additional information and notifying Claimant (if applicable)	Claimant to file Appeal	Claims Supervisor to decide Appeal
		information. *Note:* Claims Supervisor may or may not allow extension due to Claimant's failure to provide needed information.						
Post-Service Claims	No later than 30 days after receipt of claim by the Claims Supervisor	One time 15-day extension allowed if (i) due to matters beyond Claims Supervisor's control and (ii) Claims Supervisor notifies Claimant before end of initial 30-day time period of the circumstances requiring such extension and the date Claims Supervisor expects to render decision. If extension is due to Claimant's failure to submit information, notice will describe required information. *Note:* Claims Supervisor may or may not allow extension due to Claimant's failure to provide	N/A	N/A	At least 45 days after receipt of notice from Claims Supervisor *Note:* Claims Supervisor may or may not request needed information from Claimant	No later than 15 days after earlier of (i) Claims Supervisor 's receipt of additional information from Claimant, if requested, or (ii) end of time period given to Claimant to provide additional information (45 days)	180 days after receipt of Denial by Claimant If second level of appeal applies – claimant to have reasonable opportunity to pursue second appeal	60 days after Claim Supervisor's receipt of appeal from claimant

TYPE OF CLAIM	MAXIMUM TIME LIMITS FOR: Claims Supervisor to decide initial claim (if no additional information is needed) (whether adverse or not)	Extension of time by Plan for determining initial claim	Claims Supervisor to notify Claimant of information needed from Claimant to decide initial claim, if not provided by Claimant	Claims Supervisor to notify Claimant of Claimant's failure to follow proper procedures	Claimant to then provide needed information (if extension allowed by Plan)	Claims Supervisor to decide claim after requesting additional information and notifying Claimant (if applicable)	Claimant to file Appeal	Claims Supervisor to decide Appeal
		needed information.						

Section 9.3. Claims for All Other Welfare Benefits Subject to ERISA. This Section 9.03 shall apply to all claims for welfare benefits under the Plan not governed by Section 9.02.

(a) Initial Claim for Other Welfare Benefits. Any claim to receive welfare benefits (other than claims for long-term disability benefits or health benefits) under the appropriate Benefit Feature under the Plan, must be filed with the Claims Supervisor within the designated time period on the designated form, and will be deemed filed upon receipt.

(b) Initial Review of Other Welfare Benefit Claims. A claim for welfare benefits (other than claims for long-term disability benefits or health benefits) will be evaluated and the claimant will be notified of the approval or Denial within ninety (90) days after the claim is received, unless special circumstances require an extension of time to process the claim. Written notice of any extension will be furnished to the claimant prior to the termination of the initial ninety (90) day period specifying the circumstances requiring an extension and when a final decision will be reached (which will be no later than one hundred eighty (180) days after the claim was filed).

(c) Initial Denial of Other Welfare Benefits. If any claim for welfare benefits (other than long-term disability benefits or health benefits) is partially or wholly denied, the claimant will be given notice containing items (i)-(iv) under Section 9.02(c) above.

(d) Appeal of Other Welfare Benefits and Claim Denial. A claimant may Appeal the Denial of a claim for welfare benefits (other than long-term disability benefits or health benefits) by filing a written Appeal request with the Claims Supervisor within sixty (60) days after the claimant receives notification of the Denial, which will be deemed filed upon receipt. If the request is not timely, the decision of the Claims Supervisor will be the final decision of the applicable Benefit Feature, and will be final, conclusive, and binding on all persons.

(e) Denial of Other Welfare Benefit Appeals. The claimant will receive notice of the Claims Supervisor's decision on Appeal within sixty (60) days after receipt of the claimant's Appeal request, unless special circumstances require an extension of time to process the Appeal and the Claims Supervisor notifies the claimant (i) of the extension and (ii) when a final decision will be reached (which will not be later than one hundred twenty (120) days after receipt of such Appeal).

If the claim for welfare benefits (other than long-term disability benefits or health benefits) is denied on Appeal, the claimant will be given notice containing 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, as well as items (i) and (ii) under Section 9.02(c) above. A decision on review will be final, conclusive, and binding on all persons.

Section 9.4. Claims Procedures Applicable for All Claims.

(a) Authorized Representative. The Plan and any underlying Benefit Feature shall not prevent an authorized representative of a Claimant from acting on behalf of the Claimant in pursuing a benefit claim or Appeal, pursuant to reasonable procedures. In the case of an Urgent Care Claim, a Health Care Professional with knowledge of a Claimant's medical condition shall be permitted to act as the authorized representative of the Claimant.

(b) Calculating Time Periods. The period of time within which an initial benefit determination or a determination on an Appeal is required to be made will begin when a claim or Appeal is filed regardless of whether the information necessary to make a determination accompanies the filing.

Solely for purposes of initial Pre-Service Claims and Post-Service Claims if the time period for making the initial benefit determination is extended (in the Claims Supervisor's discretion) because the Claimant failed to submit information necessary to decide the claim, the time period for making the determination will be suspended from the date notification of the extension is sent to the Claimant until the earlier of (1) the date on which response from the Claimant is received, or (2) the end of the time period given to the Claimant to provide the additional information (at least forty-five (45) days).

Solely for purposes of Appeals of other welfare claims (other than health claims), if the time period for making the determination on Appeal is extended (in the Claims Supervisor's discretion) because the Claimant failed to submit information necessary to decide the Appeal, the time period for making the determination on Appeal will be suspended from the date notification of the extension is sent to the Claimant until the earlier of (1) the date on which a response from the Claimant is received, or (2) the end of the time period given to the Claimant to provide the additional information (at least forty-five (45) days).

(c) Full and Fair Review. Upon request and free of charge, the Claimant or his or her duly authorized representative will be given reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim, or may submit to the appropriate person or entity written comments, documents, records, and other information relating to the claim. If timely requested, review of a Denied claim will take into account all comments, documents, records, and other information submitted by the Claimant or his or her duly authorized representative relating to his or her claim without regard to whether such information was submitted or considered in the initial benefit determination.

Appeals for health claims will be reviewed by an appropriate named fiduciary of the Plan who is neither the individual nor subordinate of the individual who made the initial

determination. The Claims Supervisor will not give any weight to the initial determination, and, if the Appeal is based, in whole or in part, on a medical judgment, the Claims Supervisor will consult with an appropriate Health Care Professional who is neither the individual nor subordinate of the individual who was consulted in connection with the initial determination. The Claims Supervisor will identify any medical or vocational experts whose advice was obtained without regard to whether the advice was relied upon in making the benefit determination. In the case of two levels of Appeal, the second level reviewer shall not afford deference to the first level reviewer, nor shall the second level reviewer be the same individual or the subordinate of the first level reviewer.

Claimants and this Plan may have other voluntary alternative dispute resolution options, such as mediation. For available options, Claimants could contact their local U.S. Department of Labor Office and their State insurance regulatory agency.

(d) Exhaustion of Remedies. If a Claimant fails to file a request for review of a Denial, in whole or in part, of benefits in accordance with the procedures herein outlined, such Claimant will have no right to review and no right to bring action, at law or in equity, in any court and the Denial of the claim will become final and binding on all persons for all purposes.

Article X. _
SUBROGATION AND REIMBURSEMENT RIGHTS

Section 10.1. Right of Subrogation and Reimbursement. The following provisions shall apply to the subrogation and reimbursement rights of this Plan, as well as any Benefit Feature. For purposes of this Article, "Plan" shall refer to the Plan and any underlying Benefit Feature. The Plan has the right to full subrogation and reimbursement of any and all amounts paid by the Plan to, or on behalf of, a Covered Person, for which a third party is allegedly responsible. The Plan shall have a lien against such funds, and the right to impose a constructive trust upon such funds, and shall be reimbursed therefrom.

Section 10.2. Funds to Which Subrogation and Reimbursement Rights Apply. The Plan's subrogation and reimbursement rights apply if the Covered Person receives, or has the right to receive, any sum of money, regardless of whether it is characterized as amounts paid for medical expenses or otherwise, paid or payable from any person, plan, or legal entity that is legally obligated to make payments as a result of a judgment, settlement, or otherwise, arising out of any act or omission of any third party, (whether a third party or another Covered Person under the Plan): (a) who is allegedly wholly or partially liable for costs or expenses incurred by the Covered Person, in connection for which the Plan provided benefits to, or on behalf of, such Covered Person; or (b) whose act or omission allegedly caused injury or sickness to the Covered Person, in connection for which the Plan provided benefits to, or on behalf of, such Covered Person.

Section 10.3. Agreement to Hold Recovery in Trust. If a payment is made under this Plan, and the person to or for whom it is made recovers monies from a third party described in Section 10.02 as a result of settlement, judgment, or otherwise, that person shall hold in trust for the Plan the proceeds of such recovery and reimburse the Plan to the extent of its payments.

Section 10.4. Disclaimer of Make Whole Doctrine. The Plan has the right to be paid first and in full from any settlement or judgment, regardless of whether the Covered Person has been "made whole." The Plan's right is a first priority lien. The Plan's rights shall continue until the Covered Person's obligations hereunder to the Plan are fully discharged, even though the Covered Person does not receive full compensation or recovery for his or her Injuries, damages, loss or debt. This right to subrogation *pro tanto* shall exist in all cases.

Section 10.5. Disclaimer of Common Fund Doctrine. The Covered Person shall be responsible for all expenses of recovery from such third parties or other persons, including but not limited to, all attorneys' fees incurred in collection of such third-party payments, or payments by other persons. Any attorneys' fees and/or expenses owed by the Covered Person shall not reduce the amount of reimbursement due to the Plan.

Section 10.6. Obligations of the Covered Person. The Covered Person shall furnish any and all information and assistance requested by the Administrator. If requested, the Covered Person shall execute and deliver to the Administrator a subrogation and reimbursement agreement before or after any payment of benefits by the Plan. The Covered Person shall not discharge or release any party from any alleged obligation to the Covered Person or take any other action that could impair the Plan's rights to subrogation and reimbursement without the written authorization of the Administrator.

Section 10.7. Plan's Right to Subrogation. If the Covered Person or anyone acting on his or her behalf has not taken action to pursue his or her rights against a third party described in Section 10.01 above or any other persons to obtain a judgment, settlement or other recovery, the Administrator or its designee, upon giving thirty (30) days' written notice to the Covered Person, shall have the right to take such action in the name of the Covered Person to recover that amount of benefits paid under the Plan; provided, however, that any such action taken without the consent of the Covered Person shall be without prejudice to such Covered Person.

Section 10.8. Enforcement of Plan's Right to Reimbursement. If a Covered Person fails or refuses to comply with these provisions by reimbursing the Plan as required herein, the Plan has the right to impose a constructive trust over such any and all funds received by the Covered Person, or as to which the Covered Person has the right to receive. The Plan, through the Administrator, has the authority to pursue any and all legal and equitable relief available to enforce the rights contained in this Article, against any and all appropriate parties who may be in possession of the funds described herein.

Section 10.9. Withholding of Payments for Benefits. The Plan may withhold payment of benefits for an injury when a party other than the Covered Person or the Plan may be liable for expenses for that injury until liability is legally determined. In the event that any payment is made under the Plan for which any party other than the Covered Person or the Plan may be liable, the Plan shall be subrogated to all rights of recovery of the Covered Person to the extent of payments by the Plan and shall have the right to be reimbursed as set forth in this Article.

Section 10.10. Failure to Comply. If a Covered Person fails to comply with the requirements under this Article, the Covered Person shall not be eligible to receive any benefits, services or payments under the Plan for any sickness or injury until there is compliance,

regardless of whether such benefits are related to the act or omission of such third party or other persons.

Section 10.11. Future Claims Excluded. If the Covered Person receives any sum of money described in Section 10.02 above, the Plan shall have no further obligation to pay benefits relating in any way to future claims for the same or related injuries, including but not limited to any complications thereof, for which the Covered Person received such sum of money, and benefits for such future claims shall be excluded.

Section 10.12. Discretionary Authority of Administrator. The Plan, through the Administrator, shall have full discretionary authority to interpret the provisions of this Article, and to administer and pursue the Plan's subrogation and reimbursement rights. It shall be within the discretionary authority of the Administrator to resolve, settle, or otherwise compromise its subrogation and reimbursement rights when appropriate. The Administrator is under no legal obligation to reduce its lien or reimbursement rights unless, in its sole discretion, it determines that doing so is appropriate.

Article XI. _
AMENDMENT OR TERMINATION PROCEDURE

The following provisions shall apply to the amendment and termination of the Plan. To the extent that a Benefit Feature does not address amendment or termination of the Benefit Feature, the following provisions shall also apply to such Benefit Feature. The University shall have the right in its sole discretion to amend the Plan, the Schedule of Benefits or any underlying Benefit Feature, as applicable, at any time and from time to time and to any extent that it may deem advisable. Such modification or amendment shall be duly incorporated in writing. The University shall also have the right in its sole discretion to terminate the Plan or any underlying Benefit Feature at any time and to the extent that it may deem advisable. Any amendment or termination of the Plan, the Schedule of Benefits or underlying Benefit Feature shall be effective in accordance with the time limitations provided under ERISA, or such later date as the University may determine in connection therewith. To the extent allowed by ERISA, any such amendment may be effective retroactively.

Article XII. _
MISCELLANEOUS

The following provisions shall apply only to the extent such provisions are not set forth in a similar provision of a Benefit Feature provided under the Plan and/or are not inconsistent with the provisions thereof.

Section 12.1. Nonalienation. Except as otherwise required pursuant to a qualified medical child support order under ERISA Section 609, no benefit under the Plan and underlying Benefit Feature prior to actual receipt thereof by an Eligible Retiree, Dependent, or beneficiary shall be subject to any debt, liability, contract, engagement, or tort of any Eligible Retiree, Dependent, or his or her beneficiary, nor subject to anticipation, sale, assignment (except in the case of medical benefits), transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation, or any other voluntary or involuntary alienation or other legal or equitable

process, nor transferable by operation of law except as may be provided in the Benefit Feature.

Section 12.2. Additional Taxes or Penalties. If there are any taxes or penalties payable by the University on behalf of any Eligible Retiree, such taxes or penalties shall be payable by the Eligible Retiree to the University to the extent such taxes would have been originally payable by the Eligible Retiree had this Plan not been in existence.

Section 12.3. No Guarantee of Tax Consequences. Neither the Administrator nor the University makes any commitment or guarantee that any amounts paid to or for the benefit of an Eligible Retiree under the Plan shall be excludable from the Eligible Retiree's gross income for federal, state, or local income tax purposes or for Social Security tax purposes, or that any other federal or state tax treatment shall apply to or be available to any Eligible Retiree. It shall be the obligation of each Eligible Retiree to determine whether payment under the Plan is excludable from the Eligible Retiree's gross income for federal, state, and local income tax purposes, and Social Security tax purposes, and to notify the University if the Eligible Retiree has reason to believe that any such payment is not excludable.

Section 12.4. Requirement of Proper Forms. All communications in connection with the Plan made by a Participant shall become effective only when duly executed on forms provided by and filed with the Administrator.

Section 12.5. Limitation of Rights and Obligations. Neither the establishment nor maintenance of the Plan nor any amendment thereof, nor the purchase of any Benefit Feature, including any benefit contract or insurance policy, nor any act or omission under the Plan or resulting from the operation of the Plan shall be construed:

(a) as conferring upon any person any right or claim against the University, Claims Supervisor, or the Administrator, except to the extent that such right or claim shall be specifically expressed and provided in the law;

(b) as creating any responsibility or liability of the University, Administrator, or the Claims Supervisor for the validity or effect of the Plan;

(c) as a contract or agreement between the University or the Administrator and any other person;

(d) as being consideration for, or an inducement or condition of, employment of any Eligible Employee or other person, or as affecting or restricting in any manner or to any extent whatsoever the rights or obligations of the University or any Eligible Employee or other person to continue or terminate the employment relationship at any time;

(e) as giving any Eligible Employee or any other person the right to be retained in the service of the University or to interfere with the right of the University to discharge any Eligible Employee at any time; or

(f) as affecting or restricting in any manner or to the extent whatsoever the rights of the University or other person to amend, terminate, suspend, or modify the terms of the Plan or any other employee benefit plan maintained by the University.

Section 12.6. Notice. Any notice given under the Plan shall be sufficient if given to the Administrator, when addressed to its office; if given to the Claims Supervisor, when addressed to its office; or if given to an Eligible Retiree, when addressed to the Eligible Retiree at his or her address as it appears in the records of the Administrator or the Claims Supervisor.

Section 12.7. Disclaimer of Liability. Nothing contained herein shall confer upon an Eligible Retiree any claim, right, or cause of action, either at law or at equity, against the Plan, the Administrator, the University, or the Claims Supervisor for the acts or omissions or any provider of services or supplies for any benefits provided under the Plan.

Section 12.8. Right of Recovery. If the University, the Administrator, or the Claims Supervisor makes any payment that according to the terms of the Plan and the benefits provided hereunder as defined in the Schedules of Benefits should not have been made, the University, the Administrator, or the Claims Supervisor may recover that incorrect payment, whether or not it was made due to the University's, the Administrator's, or the Claims Supervisor's own error, from the person to whom it was made, or from any other appropriate party. If any such incorrect payment is made directly to an Eligible Retiree, then the University, the Administrator, or the Claims Supervisor may deduct it when making future payments directly to that Eligible Retiree.

Section 12.9. Legal Counsel. The Administrator may from time to time consult with counsel, who may be counsel for the University, and shall be fully protected in acting upon the advice of such counsel.

Section 12.10. Audit. If an audit of the Plan is required under ERISA for any Plan Year, the Administrator shall engage an independent qualified public accountant. Such audit shall be conducted in accordance with the requirements of ERISA Section 103.

Section 12.11. Bonding. Each fiduciary of the Plan, and every person who handles funds or other property of the Plan unless exempted under ERISA, shall be bonded in an amount not less than ten percent (10%) of the amounts of assets of the Plan handled by such fiduciary; provided, however, such bond shall not be less than One Thousand Dollars ($1,000) and need not be for more than Five Hundred Thousand Dollars ($500,000). The expense of such bond shall be paid from the assets of the Plan unless paid by the University.

Section 12.12. Protective Clause. Neither the University nor the Administrator shall be responsible for the validity of any contract of insurance or other benefit contract or policy by any benefit provider issued to the University or for the failure on the part of any insurance company or other benefit provider to make payments thereunder.

Section 12.13. Receipt and Release. Any payments to any Eligible Retiree shall, to the extent thereof, be in full satisfaction of the claim of such Eligible Retiree being paid thereby, and the Administrator may condition payment thereof on the delivery by the Eligible Retiree of the duly executed receipt and release in such form as may be determined by the Administrator.

Section 12.14. Legal Actions. If the Administrator is made a party to any legal action regarding the Plan, except for a breach of fiduciary responsibility of such person or persons, any and all costs and expenses, including reasonable attorneys' fees, incurred by the Administrator

in connection with such proceeding shall be paid from the assets of the Plan unless paid by the University.

Section 12.15. **Facility of Payment.** If a person who is entitled to receive payments under the Plan is physically or mentally incapable of personally receiving and giving a valid receipt for any payment due, the payment may be made to the person's personal representative as documented in writing with the University. Any such payment shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.

Section 12.16. **Reliance.** The Administrator shall not incur any liability in acting upon any notice, request, signed letter, telegram, or other paper or document believed by the Administrator to be genuine or to be executed or sent by an authorized person.

Section 12.17. **Misrepresentation.** Any material misrepresentation on the part of the Eligible Retiree making application for coverage or receipt of benefits, shall render the coverage null and void. Each Covered Person is required to notify the Administrator or Claims Supervisor of any change in status or other applicable events as required under this Plan or the applicable Benefit Features. Any failure to notify the Administrator or Claims Supervisor of any change in status or other applicable events will be deemed by the Administrator to be an act that constitutes fraud and an intentional misrepresentation of material fact prohibited by the Plan that may result in a retroactive termination of coverage.

Section 12.18. **Qualified Medical Child Support Orders.** The Plan shall provide benefits under the applicable Benefit Features in accordance with the applicable requirements of a qualified medical child support order, as required by ERISA Section 609, received by the Plan. If the Plan receives a medical child support order, the Administrator shall promptly notify the Eligible Retiree, and each child of the Eligible Retiree identified in the order, of the receipt of such order and the Plan's procedures for determining whether the order is a qualified medical child support order. Within a reasonable time after receipt of such order, the Administrator shall determine whether the order is a qualified medical child support order and notify the Eligible Retiree and each child involved of the determination. The Administrator shall establish written procedures in accordance with ERISA Section 609 to determine whether a medical child support order received by the Plan is a qualified medical child support order under ERISA.

Section 12.19. **Entire Plan.** This Plan document and the documents incorporated by reference herein shall constitute the only legally governing documents for the Plan. All statements made by the Administrator shall be deemed representations and not warranties. No oral statement or other communication shall amend or modify any provision of the Plan as set forth herein.

IN WITNESS WHEREOF, the Plan is hereby executed as follows:

DEPAUW UNIVERSITY

By:

Printed Name Brad Kelsheimer

Title: Vice President for Finance and Administration

Date: August 7, 2014

SCHEDULE A

INSURED BENEFITS

Benefit Feature	Insurance Company/Vendor	Contract/Policy
DePauw University Fully-Insured Retiree Health Plan and Trust (Grantor Trust)	Nyhart as third party administrator Schwab as custodian	N/A
DePauw University Medicare Supplemental Policy	AmWINS as third party administrator United American as insurer	2182, D2182, D2184, D2185
Group Dental Plan	Delta Dental	0414-0002 (waiting period) 0414-0001 (retirees)

Notwithstanding the above, this Schedule A shall be deemed to incorporate any other insured employee benefit programs covered by ERISA and established and maintained from time to time by the University, for the Eligible Retirees of the University.

The foregoing Schedule A was adopted in whole or in part by the University, as indicated above and may be revised, modified, changed, or added to pursuant to Article III of the Plan.

DEPAUW UNIVERSITY

By:

Printed Name Brad Kelsheimer

Title: Vice President for Finance and Administration

Date: August 7, 2014

I/3034133.5I1/3034133.5

SCHEDULE B

UNINSURED BENEFITS

Benefit Feature	Claims Supervisor	Contract/Policy
DePauw University Retiree Health Plan and Trust (VEBA)	Nyhart as third party administrator Schwab as custodian	N/A

Notwithstanding the above, this Schedule B shall be deemed to incorporate any other self-insured employee benefit programs covered by ERISA and established and maintained from time to time by the University, for the Eligible Retirees of the University.

The foregoing Schedule B was adopted in whole or in part by the University, as indicated above and may be revised, modified, changed, or added to pursuant to Article III of the Plan.

DEPAUW UNIVERSITY

By:

Printed Name Brad Kelsheimer

Title: Vice President for Finance and Administration

Date: August 7, 2014

I/3034133.5I1/3034133.5

SCHEDULE C

BENEFIT PLAN AND CONTRACTS

Documents incorporated by reference into the Plan, and made a part hereof, include the following:

- The DePauw University Fully-Insured Retiree Health Plan and Trust and all amendments thereto.
- The DePauw University Retiree Health Plan and Trust and all amendments thereto.
- The United American Insurance Company Medicare Supplemental Policy and all riders thereto.
- The United American Insurance Company Medicare Group Part D Prescription Drug Coverage
- The Delta Dental Insurance Policy and all riders thereto.

Notwithstanding the above, this Schedule C shall be deemed to incorporate any other documents relating to the insured or self-insured employee benefit programs set forth in Schedule A or Schedule B.

The foregoing Schedule C was adopted in whole or in part by the University, as indicated above and may be revised, modified, changed, or added to pursuant to Article III of the Plan.

DEPAUW UNIVERSITY

By:

Printed Name Brad Kelsheimer

Title: Vice President for Finance and Administration

Date: August 7, 2014