DEPAUW UNIVERSITY
WELFARE BENEFIT PLAN

Plan No. 502

Adopted Effective July 1, 2014

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DEPAUW UNIVERSITY WELFARE BENEFIT PLAN

ARTICLE I.
ESTABLISHMENT AND PURPOSE

Section 1.01. Preliminary Information. DePauw University ("University") previously established the Group Insurance Plan for Employees of DePauw University, the DePauw University Long Term Disability and Life Insurance Plan, and the DePauw University Flexible Spending Plan, to provide for, among other things, certain welfare benefits for eligible employees, eligible retirees, and their eligible dependents who were covered by the programs. The University now desires to establish a single employee benefit plan under which all such welfare benefits will be provided. The employee benefits provided to Eligible Employees and Eligible Retirees of the University are hereby being set forth in this plan document named the "DePauw University Welfare Benefit Plan" ("Plan"), effective July 1, 2014.

Section 1.02. Adoption of Plan. The University hereby adopts the Plan effective as of July 1, 2014.

Section 1.03. Purpose of Plan. The purpose of the Plan is to provide certain employee benefits to Eligible Employees and Eligible Retirees of the University under the Plan.

ARTICLE II.
DEFINITIONS AND RULES OF INTERPRETATION

Section 2.01. 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 2.02. Definitions. When the initial letter of a word or phrase is capitalized herein, the meaning of such word or phrase shall be as follows:

(a) "Administrator" means the University, as provided in Section 10.01. 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, Spouse or Domestic Partner for adoption, or (iii) a child who has been placed with the Eligible Employee, Eligible Retiree, Spouse 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 XI. For purposes of Article XI, 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 Employee, 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. With respect to the medical Benefit Feature, it also means a Rescission of coverage whether or not, in connection with the Rescission, there is an adverse effect on any particular health benefit at the time.

(k) "Dependent" means with respect to the medical, dental and vision Benefit Features:

(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.

For any other Benefit Feature, Dependent has the meaning set forth in the plan documents for the Benefit Feature.

(l) "Domestic Partner" means an individual of the same sex of an Eligible Employee or Eligible Retiree with respect to whom one of the following criteria have been satisfied:

(1) If the Eligible Employee or Eligible Retiree and the Domestic Partner reside in a state that recognizes a civil union or a substantially similar legal relationship, such Eligible Employee or 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 Employee or Eligible Retiree and Domestic Partner reside, such Eligible Employee or 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, but does not include:

(1) leased employees as defined under Code Section 414(n);

(2) any person who is providing services on a temporary basis or is designated to work only with respect to specific tasks or projects;

(3) any individual who enters into an agreement with the University that they are not eligible for benefits; or

(4) 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" means 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.

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

(q) "External Review" means a review of a Denial (including a Final Denial) of benefits under the medical Benefit Feature conducted on or after January 1, 2011, pursuant to the Federal External Review process described in Section 11.03(j) through (l).

(r) "Final Denial" means a Denial of benefits under the medical Benefit Feature that has been upheld by the Claims Supervisor at the completion of the internal Appeals process, pursuant to Section 11.03. (e), or a Denial of benefits under the medical Benefit Feature with respect to which the internal Appeals process has been deemed exhausted as described under Section 11.05. (d) (a "deemed Final Denial").

(s) "Final External Review Decision" means a determination by an Independent Review Organization at the conclusion of External Review.

(t) "FMLA" means the Family and Medical Leave Act of 1993, as amended from time to time.

(u) "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.

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

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

(x) "Independent Review Organization" or "IRO" means an entity that conducts independent External Reviews of Denials and Final Denials.

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

(z) "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 Employee or Eligible Retiree contributions;

(6) Risk adjusting amounts due based on an Eligible Employee's or 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 Employee's or 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.

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

(bb) "Plan Year" means the twelve (12) month period beginning on each July 1 and ending on each June 30.

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

(dd) "PPACA" means the Patient Protection and Affordable Care Act of 2010, as amended from time to time.

(ee) "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.

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

(gg) "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.

(hh) "Rescission" means a cancellation or discontinuance of coverage under the medical Benefit Feature that has retroactive effect. A Rescission does not include the cancellation or discontinuance of coverage under the medical Benefit Feature that (a) has only a prospective effect or (b) is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of such coverage.

(ii) "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.

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

(kk) "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.

(ll) "Service in the Uniformed Services" means (i) the performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, and National Guard duty under Federal law, (ii) a period for which an Eligible Employee is absent from a position of employment for the purpose of an examination to determine the fitness of the Eligible Employee to perform any such duty, (iii) a period for which the Eligible Employee is absent from employment to perform funeral honors duty as authorized by law, and (iv) service as an intermittent disaster-response appointee upon activation of the National Disaster Medical System ("NDMS") or as a participant in an authorized training program.

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

(nn) "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.

(oo) "Uniformed Service" means the Armed Forces, the Army National Guard, the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commission corps of the Public Health Service, and any other category of persons designated by the President of the United States of America in time of war or emergency. For purposes of USERRA coverage only, services as an intermittent disaster response appointee of the NDMS when federally activated or attending authorized training in support of their Federal mission is deemed Service in the Uniformed Services, although such appointee is not a member of the "uniformed services" as defined by USERRA.

(pp) "University" means DePauw University.

(qq) "Urgent Care Claim" means any claim for medical care or treatment where the failure to make a non-urgent care determination quickly (i) could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or (ii) in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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

ARTICLE III.
BENEFITS

Section 3.01. Employee Benefits.

(a) The University shall provide the employee benefits set forth in the Schedule of Benefits to Eligible Employees and Eligible Retirees pursuant to the Plan. No Eligible Employee or 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 3.02. 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 Employee or Eligible Retiree or their 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 Employees and 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 Employee or Eligible Retiree under Section 3.01(b), except as may be specifically provided by the University under Section 3.02(a).

Section 3.03. Uninsured Benefit Features.

(a) From time to time, the University may provide benefits which are not fully insured to Eligible Employees and 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 Employee 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 Employee and Eligible Retiree upon written request. No Eligible Employee or 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 Employee or Eligible Retiree under Section 3.01(c), except as may be specifically provided by the University under Section 3.03(a).

Section 3.04. 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 3.05. 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 4.01. 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 medical, dental and/or vision Benefit Feature under this 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 retiree medical and dental plan under the DePauw University Retiree Welfare Benefit Plan (the Eligible Retiree must elect coverage under the medical plan in order to participate in the dental plan); 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 Benefit Feature under this Plan pursuant to COBRA.

(b) An election under subparagraph (1) or (2) 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 Benefit Feature under this 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 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 retiree medical and dental plan under the DePauw University Retiree Welfare Benefit 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 retiree medical coverage under the DePauw University Retiree Welfare Benefit 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 4.02. Applicability. The Benefit Features under the Plan shall comply with all requirements under COBRA to the extent applicable, as described in this Article.

Section 4.03. Separately Electable Benefits. The medical benefits, dental benefits, and vision benefits and the health care flexible spending account under the DePauw University Flexible Spending Plan shall each be separately electable for COBRA purposes.

Section 4.04. 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 (including Dependent Children born to or placed for adoption with the Eligible Employee or Eligible Retiree during the continuation coverage) are eligible to elect this continuation coverage.

Section 4.05. 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 who is covered under the group health coverage under the applicable Benefit Feature on the day before a Qualifying Event (including Dependent Children born to or placed for adoption with the Eligible Employee or Eligible Retiree during the continuation coverage) who is:

(a) a covered Eligible Employee;

(b) a Spouse or Domestic Partner of a covered Eligible Employee or Eligible Retiree; or

(c) a Dependent Child of a covered Eligible Employee or Eligible Retiree (or of the Eligible Employee's or Eligible Retiree's Spouse or Domestic Partner).

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 4.06. 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 Employee or covered Eligible Retiree;

(b) the termination (other than by reason of gross misconduct) of the covered Eligible Employee's employment, or reduction of hours of a covered Eligible Employee, that would result in a termination of coverage under the group health coverage under the applicable Benefit Feature;

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

(d) the dissolution of the domestic partnership of the covered Eligible Employee from the covered Eligible Employee's Domestic Partner;

(e) the covered Eligible Employee becoming entitled to Medicare benefits under Title XVIII of the Social Security Act (42 USC § 1395-1395ggg); or

(f) a child of the covered Eligible Employee or Eligible Retiree (or of the Eligible Employee's or Eligible Retiree's Spouse or Domestic Partner) ceasing to be a Dependent Child under the eligibility requirements of the group health coverage under the applicable Benefit Feature.

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 4.07. 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 no 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 4.08. Period of Continuation Coverage.

(a) In the case of a Qualifying Event caused by termination of employment or reduction in hours, the Qualified Beneficiary may elect to extend coverage for a period of up to eighteen (18) months from the date of the Qualifying Event, unless it ends earlier as described under Section 4.09. Provided, however, with respect to the extension of coverage under the health care flexible spending account (as referenced under Section 4.03), continuation coverage shall not extend beyond the end of the calendar year in which the Qualifying Event occurs, subject to the terms and conditions of the Benefit Feature.

(b) If a second or additional Qualifying Event occurs during the initial eighteen (18) month continuation coverage period (or during a twenty-nine (29) month maximum coverage period in the case of a disability), the Qualified Beneficiary may elect to extend the continuation coverage period for a period of up to thirty-six (36) months from the date of the earlier Qualifying Event. If the covered Eligible Employee became entitled to Medicare within eighteen (18) months prior to a Qualifying Event caused by termination of employment or reduction in hours, Qualified Beneficiaries (other than the covered Eligible Employee) may elect to extend

coverage for a period of thirty-six (36) months from the date of the covered Eligible Employee's entitlement to Medicare benefits.

(c) If a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to be disabled within sixty (60) days of the initial continuation coverage period due to termination of employment or reduction of hours (even if the disability commenced, or was determined to be a disability before the first sixty (60) days of the initial eighteen (18) month continuation coverage period), coverage may be continued for all Qualified Beneficiaries for a period of up to twenty-nine (29) months from the date of the Qualifying Event. Provided, however, notice of such disability determination must be provided by the Qualified Beneficiary to the Administrator or its designee within eighteen (18) months of the Qualifying Event and within sixty (60) days after the latest of: (i) the date of the disability determination by the Social Security Administration, (ii) the date the Qualifying Event occurs, (iii) the date the Qualified Beneficiary loses or would lose coverage due to the Qualifying Event, or (iv) 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 procedures for providing such notice. The Qualified Beneficiary is responsible for notifying the Administrator or its designee within thirty (30) days of the later of: (i) the date of the final determination by the Social Security Administration that the Qualified Beneficiary is no longer disabled, or (ii) on the date which the Qualified Beneficiary is informed, via the Plan's summary plan description or the general COBRA notice, of his or her obligation to provide such notice and procedures for providing such notice.

(d) In the case of any Qualifying Event not otherwise described in subsections (a), (b), and (c), 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 4.09. <u>End of Continuation Coverage</u>. Continuation coverage shall end earlier than the period specified under Section 4.08:

(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;

(c) if the Qualified Beneficiary first becomes entitled to benefits under Medicare, after the date on which continuation coverage is elected;

(d) if the University ceases to provide any group health plan to any employee;

(e) if the Qualified Beneficiary ceases to be disabled, if continuation coverage is due to the disability; or

(f) if the period of continuation coverage expires as set forth in Section 4.08 (with respect to the health care flexible spending account under the DePauw University Flexible Spending Plan, this period shall not extend beyond the end of the calendar year in which the Qualifying Event occurs).

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 4.10. 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 4.11. Notification Requirements.

(a) General Notice to Covered Eligible Employee/Eligible Retiree and Spouse/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 Employee and covered Eligible Retiree and to his or her Spouse or Domestic Partner (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 Employee and his or her Spouse or Domestic Partner (or a covered Eligible Retiree and the covered Eligible Retiree's Spouse or Domestic Partner) if they both reside at the covered Eligible Employee or covered Eligible Retiree address, and the Spouse's or Domestic Partner's coverage commences on or after the date on which the covered Eligible Employee's or covered Eligible Retiree's coverage commences, but not later than the date by which this general notice must be provided under this subparagraph (a). No separate notice is required to be sent to Dependent Children who share a residence with a covered Eligible Employee or his or her Spouse (or a covered Eligible Retiree or a covered Eligible Retiree's Spouse). 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 (i) a covered Eligible Employee's death, termination of employment (other than gross misconduct), reduction in hours, or entitlement to Medicare benefits, or (ii) a covered Eligible Retiree's death within thirty (30) days after the date of the Qualifying Event.

(c) Covered Employee/Eligible Retiree/Qualified Beneficiary Notice to Administrator. The covered Eligible Employee or covered Eligible Retiree or Qualified Beneficiary, as applicable in the following situations, must notify the Administrator or its designee of: (i) a divorce or legal separation of the covered Eligible Employee or covered Eligible Retiree from the covered Eligible Employee's or covered Eligible Retiree's Spouse, (ii) the dissolution of the Domestic Partner and covered Eligible Employee's or covered Eligible Retiree's relationship, (iii) a child ceasing to be a Dependent Child under the eligibility requirements of the group health coverage under the applicable Benefit Feature, (iv) a second Qualifying Event, or (v) notice of disability entitlement or cessation of disability. Notification must occur as soon as possible, and for events under (i), (ii), (iii), or (iv) above, such notice must occur 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. See Section 4.08 for timing of notices applicable to disability determinations.

The covered Eligible Employee, covered Eligible Retiree, Qualified Beneficiary, or a representative acting on behalf of the covered Eligible Employee, 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 § 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 4.11(b) or (c), 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. Any notification to a Qualified Beneficiary who is the Spouse of the covered Eligible Employee or covered Eligible Retiree shall be treated as a notification to all other Qualified Beneficiaries residing with such Spouse at the time such notification is made.

(e) Unavailability of Coverage. If the Administrator or its designee receives a notice of an applicable Qualifying Event or disability determination under Section 4.11(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 4.11(d) 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 Sections 4.11(d), (e) and (f) must be provided to each Qualified Beneficiary or individual; however (i) a single notice can be provided to the covered Eligible Employee and the covered Eligible Employee's Spouse or Domestic Partner (or the covered Eligible Retiree and the covered Eligible Retiree's Spouse or Domestic Partner) if the Spouse or Domestic Partner resides with the covered Eligible Employee or covered Eligible Retiree, and/or (ii) a single notice can be provided to the covered Eligible Employee or the covered Eligible Employee's Spouse (or the covered Eligible Retiree or the covered Eligible Retiree's Spouse) for a Dependent Child of the covered Eligible Employee (or the covered Eligible Retiree), if the Dependent Child resides with the covered Eligible Employee or the covered Eligible Employee's Spouse (or the covered Eligible Retiree or the covered Eligible Retiree's Spouse).

Section 4.12. 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 4.13. 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 Employee or 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 Employee or 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.
FAMILY AND MEDICAL LEAVE ACT

Section 5.01. Applicability. The Plan, through the appropriate Benefit Feature under the Plan, shall provide continuation coverage consistent with the provisions of the FMLA.

Section 5.02. Coverage During FMLA Leaves.

(a) The FMLA generally allows certain employees who worked at least twelve hundred fifty (1,250) hours during the preceding twelve (12) months the right to take an unpaid leave (or a paid leave if it has been earned) for a period of up to twelve (12) work weeks during a twelve (12) month period because of (i) the birth of a child and to care for such child, (ii) the placement of a child for adoption or foster care, and to care for such child, (iii) the need to care for a family member (child, spouse, or parent) with a "serious health condition" as defined under the FMLA, (iv) an employee's own "serious health condition" that makes the employee unable to do his or her job, or (v) any "qualifying exigency" (as defined under the FMLA) arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation.

(b) In addition, any spouse, son, daughter, parent, or nearest blood relative ("next of kin") of a "covered servicemember" shall be granted leave not to exceed a total of twenty-six (26) work weeks during a single twelve (12) month period to care for the "covered servicemember." During the single twelve (12) month period described above, an Eligible Employee may be granted a combined total of twenty-six (26) work weeks of leave for any combination of leaves under the FMLA. For purposes of this policy, the phrase "covered servicemember" means a member of the Armed Forces, including a member of the National Guard or Reserves, who: (i) is undergoing medical treatment, recuperation, or therapy; (ii) is otherwise in an "outpatient status" (as defined by regulations); or (iii) is otherwise on the temporary disability retired list, for a "serious injury or illness" (as defined by regulations).

(c) Notwithstanding any other provisions in the Plan or any applicable Benefit Feature to the contrary, under the FMLA, an Eligible Employee who is covered under the Plan is entitled to continue health benefit coverage under the applicable Benefit Feature during the period the Eligible Employee is on a FMLA leave. If paid leave runs concurrently with FMLA leave, employee contributions must be made by payroll deduction under the DePauw University Flexible Spending Plan or by whatever alternative method is normally utilized for making such contributions when the Eligible Employee is on paid leave. If the FMLA leave is unpaid leave, employee contributions may be made on a catch-up basis under the University's existing rules for payments by Eligible Employees on an unpaid leave. Upon return from FMLA leave, the Eligible Employee must make up the required employee contributions he or she missed during the leave. The health benefit coverage provided pursuant to the FMLA under the applicable Benefit Feature is the same as would be provided if the Eligible Employee had been employed during the leave period. The Eligible Employee may choose not to continue health benefit

coverage under the applicable Benefit Feature during the FMLA leave in which case the Eligible Employee shall be immediately reinstated to health benefit coverage under the applicable Benefit Feature when the Eligible Employee returns from the FMLA leave without regard to any waiting period. The Eligible Employee's right to continue coverage for non-health benefits shall be governed by the right to continue such coverages during non-FMLA type leaves. The Eligible Employee shall be notified of such right, if any, to continue other benefit coverage during a FMLA leave.

(d) Except as provided under Article IV, FMLA benefit coverage shall terminate when:

(1) the Eligible Employee informs the University of his or her intent not to return from FMLA leave;

(2) the Eligible Employee fails to return from the FMLA leave; or

(3) the Eligible Employee exhausts his or her FMLA leave.

(e) Eligible Employees shall pay any applicable employee contributions in accordance with the applicable Benefit Feature.

(f) The University may recover from the Eligible Employee: (i) contributions made by the University during a period of unpaid FMLA leave for maintaining the employee's health benefit coverage if the Eligible Employee fails to return to work after the FMLA leave has been exhausted, unless the failure to return to work is due to a serious health condition of the Eligible Employee or a family member or other circumstances beyond the Eligible Employee's control; or (ii) the Eligible Employee's share of contributions the Eligible Employee was obligated to make but which the University elected to make on the Eligible Employee's behalf in order to maintain the Eligible Employee's health benefit coverage (or non-health benefit coverage, as appropriate), regardless of whether the Eligible Employee returns from such leave.

ARTICLE VI.
LAWS AFFECTING BENEFIT FEATURES

Section 6.01. 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. Such compliance shall include the following:

(a) Certificates of Coverage. The University shall provide Eligible Employees certification of their coverage under the affected Benefit Feature to the extent required by HIPAA. The University may delegate the administrative functions associated with such certifications, including the issuance of such certifications, to appropriate individuals and/or entities.

(b) Special Enrollment Periods.

(1) Notwithstanding any other provisions in this Plan or in the affected Benefit Feature to the contrary, eligible individuals shall be entitled to enroll in the affected Benefit Feature during special enrollment periods upon the loss of other coverage or upon the acquisition of a new Dependent to the extent required under HIPAA.

(2) Notwithstanding any other provisions in this Plan or in the affected Benefit Feature to the contrary, eligible individuals shall be entitled to be enrolled in the affected Benefit Feature during special enrollment periods if: (i) the eligible individual is covered under a Medicaid plan under Title XIX of the Social Security Act, or a state children's health plan under Title XXI of the Social Security Act; and (ii) coverage under such plans is lost due to a loss of eligibility for such coverage. In addition, an eligible individual may be enrolled under an applicable Benefit Feature if the eligible individual becomes eligible for premium assistance, with respect to the applicable Benefit Feature, under such Medicaid plan or a state children's health plan (including any waiver or demonstration project conducted under or in relation to such plan), to the extent required under HIPAA.

(c) Pre-Existing Condition Exclusions. Notwithstanding any other provisions in this Plan or in the affected Benefit Feature to the contrary, no pre-existing conditions shall be excluded from coverage under the affected Benefit Feature to the extent such exclusion would violate HIPAA or PPACA. Effective January 1, 2011, no pre-existing condition shall be imposed on any child under the age of nineteen (19) under the medical Benefit Feature.

(d) Discrimination Based on Health Status-Related Factors Prohibited. Notwithstanding any other provisions in this Plan or in the affected and applicable Benefit Feature to the contrary, no person shall be discriminated against in terms of eligibility, continued eligibility, or level of required employee contribution based on the following health status-related factors: (i) health status; (ii) medical condition (including both physical and mental illnesses); (iii) claims experience; (iv) receipt of health care; (v) medical history; (vi) genetic information, as that term is defined in HIPAA; (vii) evidence of insurability (including conditions arising out of acts of domestic violence); or (viii) disability.

Section 6.02. Genetic Information Nondiscrimination Act of 2008. Further, 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 otherwise 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 a 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 6.03. Mental Health Parity 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 provides both medical and surgical benefits and mental health or substance use disorder benefits, and which is obligated to meet the requirements of the Mental Health Parity Act of 1996, as amended by the Mental Health Parity and Addiction Equity Act of 2008, and as amended from time to time thereafter, effective January 1, 2010, shall satisfy these Acts to the extent required thereunder and not otherwise inconsistent with any federal law or regulations governing such Benefit Feature.

Section 6.04. 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 6.05. Women's Health and Cancer Rights Act of 1998. Any group health plan which is a part of this Plan as a Benefit Feature which is obligated to meet the requirements of the Women's Health and Cancer Rights Act of 1998 shall comply with the Women's Health and Cancer Rights Act of 1998, 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.

Section 6.06. Eligibility for Medicaid Benefits. Benefits shall be paid in accordance with any assignment of rights made by or on behalf of any Eligible Employee or Dependent as required by a state plan for medical assistance approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act. For purposes of enrollment and entitlement to benefits, an Eligible Employee's or Dependent's eligibility for or receipt of medical benefits under a state plan for medical assistance approved under Title XIX of the Social Security Act shall not be taken into account. The state shall have a right to any payment made under a state plan for medical assistance approved under Title XIX of the Social Security Act when the Plan has a legal liability to make such payment.

Section 6.07. Dependent Students on Medically Necessary Leave of Absence. 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 Michelle's Law of 2008, relating to the coverage of Dependent students while on medically necessary leaves of absence, shall comply with Michelle's Law of 2008, as amended from time to time, and any regulations issued thereunder, to the extent required thereunder and not otherwise inconsistent with any federal law or regulations governing such Benefit Feature.

Section 6.08. Patient Protection and Affordable Care Act of 2010. Any group health plan which is a part of this Plan as a Benefit Feature, and which is obligated to meet the requirements of PPACA, shall comply with PPACA, 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 6.09. Prohibition on Rescissions under Medical Benefit Feature. Any group health plan which is a part of this Plan as a Benefit Feature, and which is obligated to meet the requirements of Section 2712 of the Public Health Service Act, as added by Section 1001 of the PPACA and incorporated into ERISA Section 715, relating to the prohibition on Rescissions, shall comply with Section 2712 of the Public Health Service Act, 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. Notwithstanding the foregoing, the Plan or applicable Benefit Feature may still cancel or discontinue coverage effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Nothing in this Section shall prohibit the Plan or applicable Benefit Feature from cancelling or discontinuing such coverage prospectively for any reason provided under the Plan or applicable Benefit Feature.

ARTICLE VII.
PROTECTED HEALTH INFORMATION

Section 7.01. Adoption. 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 7.02. 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 7.03. 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 7.04. Plan Documents. 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 or HMO 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 7.05. Disclosures by Plan to the University. 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 Sections 7.06 to 7.08 of this Article.

(d) With an authorization from the Eligible Employee or 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 7.06. Uses and Disclosures by the University. 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 Employee or 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 7.05.

Section 7.07. 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 in this Section and that the University so agrees to the provisions set forth therein.

Section 7.08. 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 Sections 7.09, 7.10, and 7.11 of the Plan are supported by reasonable and appropriate security measures.

Section 7.09. 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 7.10. Limitations of Access and Disclosure. The persons described in Section 7.09 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 7.11. Noncompliance. If the persons or classes of persons described in Section 7.09 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 VIII.
USERRA RIGHTS AND COVERAGE

Section 8.01. Applicability. The Benefit Features under the Plan shall comply with all requirements under the USERRA to the extent applicable, and as described below.

Section 8.02. USERRA Continuation Coverage.

(a) An Eligible Employee may be entitled to reemployment and other rights during and after a period of Service in the Uniformed Services under USERRA, including certain contributions and service credits under the applicable Benefit Features that are subject to USERRA. Each Benefit Feature shall be administered in compliance with the requirements of USERRA to the extent applicable.

(b) To be eligible for such USERRA benefits, before leaving for military service, the Eligible Employee is generally required to give the University advance notice that such Eligible Employee is leaving the job for Service in the Uniformed Services. When such Eligible Employee returns from military service, he or she must timely submit an application for reemployment with the University and request information regarding such Eligible Employee's reemployment rights. Time limits for returning to work shall depend on the length of time of such military service.

Section 8.03. Continuation of Coverage. If an Eligible Employee is absent from a position of employment with the University by reason of Service in the Uniformed Services and was covered under a group health plan under a Benefit Feature that is required to provide continuation coverage under 38 USC § 4317 immediately prior to his or her absence due to Service in the Uniformed Services, such Eligible Employee shall then be entitled to elect to continue health care coverage under the applicable Benefit Feature for the Eligible Employee and his or her covered Dependents for the time period allowed under the applicable Benefit Feature. Thereafter, coverage will continue for a period equal to the lesser of (i) the twenty-four (24) month period beginning on the date on which such Eligible Employee is absent from employment with the University by reason of Service in the Uniformed Services or (ii) the day following the date on which the Eligible Employee fails to apply for or return to a position of employment with the University as determined pursuant to USERRA Section 4312(e). Eligible Employees may elect to discontinue coverage under the Plan during Service in the Uniformed Services by submitting the applicable forms to the University.

Section 8.04. Election of USERRA Continuation Coverage. Continuation coverage does not begin unless it is elected by the Eligible Employee.

(a) The Eligible Employee may elect to continue coverage described in Section 8.02 by reason of Service in the Uniformed Services for himself or herself and his or her covered Dependents. Dependents do not have an independent right to elect USERRA continuation coverage. The election period for continued coverage shall begin on the date the Eligible Employee gives the University advance notice that he or she is required to report for Uniformed Service (whether such service is voluntary or involuntary) and shall end sixty (60) days after the date the Eligible Employee would otherwise lose coverage under the applicable Benefit Feature.

(b) If the Eligible Employee is unable to give advance notice of Uniformed Service, the Eligible Employee may still be able to elect continuation coverage under this Article if the failure to give advance notice was because giving such notice was impossible, unreasonable, or precluded by military necessity. In such a case, the election period shall begin on the date the Eligible Employee leaves for Uniformed Service and shall end on the earlier of: (i) the twenty-four (24) month period beginning on the date on which the Eligible Employee's absence for the Uniformed Service begins; or (ii) the date on which the Eligible Employee fails to return from Uniformed Service or apply for a position of employment as provided under 20 CFR §§ 1002.115-123. For these purposes, "military necessity" occurs only when deemed to be so by a designated military authority as described in 20 CFR § 1002.86 and may include situations where a mission, operation, exercise or requirement is classified, or could be compromised or otherwise adversely affected by public knowledge. It may be impossible or unreasonable to give advance notice under certain circumstances such as when the University is unavailable or the Eligible Employee is required to report for Uniformed Service in an extremely short period of time.

(c) The election of USERRA continuation coverage must be made on a form provided by the Administrator and made within the sixty (60) day period described herein. An election is considered to be made on the date it is sent to the Administrator. If timely elected pursuant to this Section, coverage shall be reinstated as of the date the Eligible Employee lost coverage due to absence for Service in the Uniformed Service and shall last for the period set forth in Section 8.02; provided that the Eligible Employee pays all unpaid costs for the coverage pursuant to Section 8.04.

Section 8.05. Cost of USERRA Continuation Coverage. If an Eligible Employee and/or the eligible covered Dependent(s) of such Eligible Employee elect continuation coverage pursuant to Section 8.01, such Eligible Employee and/or eligible covered Dependent(s) shall be required to pay one hundred two percent (102%) of the full premium cost for such coverage; provided, however, if such Eligible Employee's Service in the Uniformed Services is for a period of fewer than thirty-one (31) days, such person(s) shall not be required to pay more for such coverage than is otherwise required for eligible persons.

Premiums are due on the first day of each month for which continuation coverage is desired. 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 also be paid for the cost of continuation coverage for the time period between the date that continuation coverage commences and the date continuation coverage is elected. This payment must be made within forty-five (45) days after the date of election. 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 8.06. Coordination with COBRA. An Eligible Employee who is absent from work by reason of Service in the Uniformed Services may be eligible for continuation coverage under Article IV. The continuation coverage provided in this Article shall not limit or otherwise interfere with those continuation coverage rights detailed in Article IV; provided, however, any continuation coverage provided under this Article shall run concurrently with any continuation coverage available under Article IV.

Section 8.07. USERRA Continuation Health Benefits Provided. The continuation coverage provided to an Eligible Employee serving in the Uniformed Services who elects continued coverage (and his covered Dependents) shall be identical to the coverage provided under the group health coverage to similarly situated persons covered by the group health coverage who are active. 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 covered under USERRA continuation 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 individuals who have elected USERRA continuation coverage.

Section 8.08. Waiting Period and Exclusions Upon Reemployment. Notwithstanding any other provision herein, an Eligible Employee and his or her eligible covered Dependents whose benefit coverage is terminated by reason of Service in the Uniformed Services shall not be subject to any exclusion or waiting period upon reinstatement of such coverage under the group health coverage under the applicable Benefit Feature following Service in the Uniformed Services; provided, however, the above shall not apply to any condition determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during the performance of Service in the Uniformed Services.

Section 8.09. Reinstatement of Coverage Upon Reemployment. The University shall promptly reinstate the group health plan coverage under the applicable Benefit Feature at reemployment upon request, consistent with the terms of the applicable Benefit Feature.

Section 8.10. Rights, Benefits, and Obligations of Employees Absent from Employment by Reason of Service in the Uniformed Services. An Eligible Employee who is absent from employment with the University by reason of Service in the Uniformed Services shall be considered on furlough or leave of absence while performing such service and shall be entitled to such other rights and benefits as are generally provided by the University to Eligible Employees having similar status and pay who are on furlough or leave of absence; provided, however, an Eligible Employee who knowingly provides written notice of intent not to return to employment with the University shall cease to be entitled to such rights and benefits. Furthermore, an Eligible Employee who is absent from employment with the University by

reason of Service in the Uniformed Services shall be permitted to apply any accrued paid vacation, annual or similar leave while on such leave by reason of Service in the Uniformed Services.

ARTICLE IX.
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 Employee contributions or Eligible Retiree contributions, as applicable. The University shall determine the amount, if any, of contributions to be made by each Eligible Employee or Eligible Retiree with respect to each Benefit Feature. Eligible Employee or Eligible Retiree contributions for Benefit Features shall be communicated to Eligible Employees and Eligible Retirees. Certain Eligible Employee contributions shall be treated as University contributions consistent with the DePauw University Flexible Spending Plan.

ARTICLE X.
ADMINISTRATION OF THE PLAN

Section 10.01. 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 10.02. 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 10.03. 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. Except as provided under Section 11.03(h) through (j) below with respect to the External Review Process, 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 10.04. 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 10.05. 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 XI.

Section 10.06. 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 XI.
CLAIMS PROCEDURES

Section 11.01. 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 11.02 shall apply to claims for long-term disability benefits subject to the requirements of ERISA Section 503, Section 11.03 shall apply to health claims, Section 11.04 shall apply to claims for all other welfare plans subject to the requirements of ERISA Section 503, and Section 11.05 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 11.02 through 11.04) may be done in writing or electronically, unless otherwise designated.

Section 11.02. Claims for Long-Term Disability Benefits.

(a) Initial Claim for Long-Term Disability Benefits. Any claim to receive long-term disability 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. The Claimant must submit any required physician statements on the appropriate form establishing that the Eligible Employee is disabled (as defined and set forth under the applicable long-term disability Benefit Feature). If the Claims Supervisor disagrees as to a Claimant's initial or continuing long-term disability benefits, the terms of the applicable long-term disability Benefit Feature will be followed in resolving any such dispute. Upon a finding of a disability, the Claimant will be deemed disabled as of the commencement of such disability.

(b) Initial Review of Long-Term Disability Benefit Claims. When a claim for long-term disability benefits has been properly filed, the Claimant will be notified of the approval or Denial within forty-five (45) days after the claim is received. If special circumstances require an extension of time for processing the claim, the forty-five (45) day period may be extended for up to two different extension periods, each consisting of thirty (30) additional days. Written notice of the extension(s) will be furnished to the Claimant prior to the expiration of the initial forty-five (45) day period and the first thirty (30) day extension period, as applicable, and will (i) specify the reasons for the extension(s) and when a final decision will be reached, and (ii) explain the standards for payment, the unresolved issues that prevent a decision, and the information needed to resolve those issues. The Claimant will have forty-five (45) days to provide any specified information to the Claims Supervisor.

(c) Initial Denial of Long-Term Disability Benefit Claims. If any claim for long-term disability benefits is partially or wholly Denied, the Claimant will be given notice which will contain: (i) the specific reasons for the Denial; (ii) references to applicable Benefit Feature provisions upon which the Denial is based; (iii) a description of any additional material or information needed and why such material or information is necessary; (iv) a description of the review procedures and time limits; (v) 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 (vi) 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.

(d) Appeal of Long-Term Disability Benefit Claim Denial. A Claimant may Appeal the Denial of a claim for long-term disability benefits by filing a written claim Appeal with the Claims Supervisor within one hundred eighty (180) days after the Claimant receives notice of the Denial, and 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 Long-Term Disability Benefit Appeal. The Claimant will receive notice of the Claims Supervisor's decision on Appeal within forty-five (45) 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 ninety (90) days after receipt of such Appeal).

If the long-term disability benefit claim 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), (ii), (v), and (vi) under paragraph (c) above. A decision on review will be final, conclusive, and binding on all persons.

Section 11.03. 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 under subsection (i) below. For Urgent Care Claims, the Claims Supervisor will defer to the attending provider with respect to the decision as to whether a claim is an Urgent Care Claim for purposes of determining the applicable time period.

(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, information on the External Review process (with respect to benefits under the medical Benefit Feature), 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;

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

(8) for Denials of benefits under the medical Benefit Feature, (A) information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning), (B) the Denial code and its corresponding meaning, as well as a description of the Claims Supervisor's standard, if any, that was used in the Denial of the claim, and (C) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist individuals with the internal claims and Appeals and External Review processes.

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 of 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 the first level of Appeal, the Claims Supervisor will provide notice to the Claimant containing the information set forth in subparagraph (3) of this subsection (e). If the Claimant does not

file a timely second level of Appeal, the decision on the first level of 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 Final 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 Final Denial, if any.

(3) In addition, if the health claim is denied on Appeal (including a Final Denial), 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, information on the External Review process (with respect to benefits under the medical Benefit Feature), 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;

(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;

(F) effective January 1, 2011, for Denials of benefits under the medical Benefit Feature, (i) information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning), (ii) the Denial code and its corresponding meaning, as well as a description of the Claims Supervisor's standard, if any, that was used in the Denial of the claim, and (iii) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist

individuals with the internal claims and Appeals and External Review process; and

(G) for Denials of benefits under the medical Benefit Feature, if the Denial is a Final Denial, a discussion of the decision.

Except as provided in Section 11.03(j) through (l) below with respect to claims for benefits under the medical Benefit Feature, the decision on review will be final, conclusive, and binding on all persons.

(f) Second Level Appeal of Health Benefit Claim Denial. 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 Section 11.03(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 11.03(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.

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
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	All appeals (first and/or second levels, as applicable) must be decided within 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	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	One Level Appeal: 30 days after Claim Supervisor's receipt of appeal from claimant Two Level Appeal: *First level* – 15 days after Claim Supervisor's receipt of claimant's first level appeal request *Second level* – 15 days after Claim Supervisor's receipt of claimant's second level appeal request

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
		required 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	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	One Level Appeal: 60 days after Claim Supervisor's receipt of appeal from claimant Two Level Appeal: *First level* – 30 days after Claim Supervisor's receipt of claimant's first level appeal request *Second level* – 30 days after Claim Supervisor's receipt of claimant's second level appeal request

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
		due to Claimant's failure to provide needed information.						

(j) Application and Scope of Federal External Review Process for Benefits Under the Medical Benefit Feature.

(1) Subject to subsection (2) below, upon receipt of a Final Denial (including a deemed Final Denial) with respect to benefits under the medical Benefit Feature, the Claimant may apply for External Review as provided in Section 11.03(k) or (l) below, as applicable. Upon receipt of a Denial with respect to benefits under the medical Benefit Feature that is not a Final Denial, the Claimant may only apply for External Review as provided under Section 11.03(l)(1)(A) regarding expedited External Review for Urgent Care Claims.

(2) With respect to claims for which External Review is initiated before September 20, 2011, a Claimant may request External Review for any Final Denial or eligible Denial with respect to benefits under the medical Benefit Feature, except that a denial, reduction, termination, or failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility based under the terms of the medical Benefit Feature is not eligible for External Review. With respect to claims for which External Review is initiated on or after September 20, 2011, the External Review process will apply only to:

(A) a Final Denial or eligible Denial with respect to benefits under the medical Benefit Feature that involves medical judgment (including, but not limited to, those based on the medical Benefit Feature's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational; and

(B) a Rescission of coverage under the medical Benefit Feature (whether or not the Rescission has any effect on any particular benefit at that time).

(k) Standard External Review Process for Claims for Benefits Under the Medical Benefit Feature.

(1) Timing of Request for External Review. The Claimant must file a request for External Review of a benefit claim under the medical Benefit Feature with the Claims Supervisor no later than the date which is four (4) months following the date of receipt of a notice of Final Denial. If there is no corresponding date four (4) months after the date of receipt of such notice, then the request must be filed by the first day of the fifth month following receipt of the notice (*e.g.*, if a Final Denial is received on October 30, request must be made by the following March 1). If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(2) Preliminary Review. The Claims Supervisor shall complete a preliminary review of the request for External Review within five (5) business days to determine whether (A) the Claimant is or was covered under the applicable Benefit Feature at the time the Covered Service was requested or provided, as applicable; (B) the type of claim is eligible for External Review; (C) the Claimant has exhausted (or is deemed to have exhausted) the Plan's internal claims and Appeals process under Section 11.05(d); and (D) the Claimant has provided all the information and forms required to process an External Review. The Claims Supervisor shall issue a notification to the Claimant within one (1) business day of completing the preliminary review. If the request is complete, but ineligible for External Review, the notification shall include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification shall describe the information or materials needed to make the request complete, and the Claimant shall be allowed to perfect the request for External Review by the later of the four (4) month filing period described in subsection (1) above, or within the forty-eight (48) hour period following the receipt of the notification.

(3) Referral to Independent Review Organization (IRO). The Claims Supervisor shall assign an IRO to the Claimant's request for External Review. Upon assignment, the IRO will undertake the following tasks with respect to the request for External Review:

(A) Timely notify the Claimant in writing of the request's eligibility and acceptance for External Review. This notice will include a statement that the Claimant may submit in writing to the IRO, within ten (10) business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days.

(B) Review all documents and any information considered in making a Final Denial received by the Claims Supervisor. The Claims Supervisor shall provide the IRO with such documents and information within five (5) business days after the date of assignment of the IRO. Failure by the Claims Supervisor to timely provide the documents and information shall not delay the conduct of the

External Review. If the Claims Supervisor fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Final Denial. In such case, the IRO shall notify the Claimant and the Claims Supervisor of its decision within one (1) business day.

(C) Forward any information submitted by the Claimant to the Claims Supervisor within one (1) business day of receipt. Upon receipt of any such information, the Claims Supervisor may reconsider its Final Denial that is the subject of the External Review. Reconsideration by the Claims Supervisor must not delay the External Review. The External Review may be terminated as a result of reconsideration only if the Claims Supervisor decides to reverse its Final Denial and provide coverage or payment. In such case, the Claims Supervisor must provide written notice of its decision to the Claimant and IRO within one (1) business day, and the IRO shall then terminate the External Review.

(D) Review all information and documents timely received under a *de novo* standard. The IRO shall not be bound by any decisions or conclusions reached during the Claims Supervisor's internal claims and Appeals process. In addition to the information and documents provided, the IRO, to the extent the information and documents are available and the IRO considers them appropriate, shall further consider the following in reaching a decision: (i) the Claimant's medical records; (ii) the attending Health Care Professional's recommendation; (iii) reports from appropriate Health Care Professionals and other documents submitted by the Claims Supervisor, the Claimant, or the Claimant's physician; (iv) the terms of the applicable Benefit Feature to ensure that the IRO's decision is not contrary to the terms of the Benefit Feature, unless the terms are inconsistent with applicable law; (v) appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations; (vi) any applicable clinical review criteria developed and used by the Benefit Feature, unless the criteria are inconsistent with the terms of the Benefit Feature or with applicable law; and (vii) the opinion of the IRO's clinical reviewer(s) after considering the information described in this paragraph to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.

(4) Notice of Final External Review Decision. The IRO shall provide written notice of Final External Review Decision within forty-five (45) days after the IRO receives the request for External Review. Such notice shall be delivered to the Claimant and the Claims Supervisor and shall contain the following: (A) a general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous Denial); (B) the date the IRO received the assignment to conduct External Review and the date of the Final External Review Decision; (C) references to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in

reaching the decision; (D) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied upon in making its decision; (E) a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Benefit Feature or the Claimant; (F) a statement that judicial review may be available to the Claimant; and (G) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

(5) Reversal of Plan's Decision. If the Final Denial of the Claims Supervisor is reversed by the Final External Review Decision, the applicable Benefit Feature shall immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for a claim, upon receipt of notice of such reversal.

(6) Maintenance of Records. The IROs shall maintain records of all claims and notices associated with an External Review for six (6) years. An IRO must make such records available for examination by the Claimant, the Claims Supervisor, or a state or Federal oversight agency upon request, except where such disclosure would violate state or Federal privacy laws.

(l) Expedited External Review Process for Claims for Medical Benefits or Prescription Drug Benefits.

(1) Application of Expedited External Review. The Plan shall allow the Claimant to make a request for expedited External Review at the time the Claimant receives either:

(A) A Denial with respect to benefits under the medical Benefit Feature, if the Denial involves a medical condition of the Claimant for which the timeframe for completion of an internal Appeal of an Urgent Care Claim would seriously jeopardize the Claimant's life or health or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an Appeal of an Urgent Care Claim; or

(B) A Final Denial with respect to benefits under the medical Benefit Feature, if the Claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the Claimant's life or health or would jeopardize the Claimant's ability to regain maximum function, or if the Final Denial concerns admission, availability of care, continued stay, or a health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

(2) Preliminary Review. Immediately upon receipt of a request for expedited External Review, the Claims Supervisor must determine whether the request meets the reviewability requirements set forth in subsection (1) above. The Claims Supervisor shall immediately send a notice that meets the requirements set forth in Section 11.03. (k)(2) above for standard External Review of the Claimant for its eligibility determination.

(3) Referral to Independent Review Organization (IRO). Upon a determination that a request is eligible for expedited External Review following the preliminary review, the Claims Supervisor shall assign an IRO pursuant to the requirements set forth in Section 11.03. (k)(3) above for standard External Review. The Claims Supervisor must provide or transmit all necessary documents and information considered in making the Denial or Final Denial determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the information or documents described under Section 11.03. (k)(3)(D) above under the procedures for standard External Review. In reaching a decision, the assigned IRO shall review the claim *de novo* and is not bound by any decisions or conclusions reached during the Claims Supervisor's internal claims and Appeals process.

(4) Notice of Final External Review Decision. The IRO shall provide notice of Final External Review Decision, in accordance with the requirements set forth in Section 11.03. (k)(4) above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited External Review. If the notice is not in writing, within forty-eight (48) hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to the Claimant and the Claims Supervisor.

(m) Form and Manner of Notices Pertaining to Claims Under the Medical Benefit Feature. Effective January 1, 2011, notices provided pursuant to this Section with respect to internal claims and Appeals and External Reviews with respect to benefits under the medical Benefit Feature shall be provided in a culturally and linguistically appropriate manner pursuant to Department of Labor regulations. Accordingly, with respect to an address in any United States county to which a notice is sent, if 10% or more of the population residing in the county is literate only in the same non-English language (the "applicable non-English language"), the Claims Supervisor will: (1) provide oral language services (such as a telephone customer assistance hotline) that include answering questions in the applicable non-English language; (2) provide notices sent under this Section with respect to the medical Benefit Feature in the applicable non-English language upon request; and (3) include a statement in the English versions of all notices sent under this Section with respect to the medical Benefit Feature, prominently displayed in the applicable non-English language, clearly indicating how to access the language services provided by the Plan.

Section 11.04. Claims for All Other Welfare Benefits Subject to ERISA. This Section 11.04 shall apply to all claims for welfare benefits under the Plan not governed by Sections 11.02 and 11.03.

(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 11.02(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 11.02(c) above. A decision on review will be final, conclusive, and binding on all persons.

Section 11.05. 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, Post-Service Claims, and long-term disability 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 long-term disability claims and 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 (1) long-term disability claims or (2) 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.

(1) 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.

(2) With respect to claims under the medical Benefit Feature, on or after January 1, 2011, except as provided under subparagraph (3) below, if the Claims Supervisor fails to strictly adhere to all the requirements with respect to a claim under Section 11.03(a) through (i), the Claimant is deemed to have exhausted the internal claims and Appeals process with respect to such claims. Accordingly, the Claimant may initiate an External Review with respect to such claims as outlined in Sections 11.03(j), (k), and (l) above. The Claimant also is entitled to pursue any available remedies under ERISA Section 502(a) or state law, as applicable, with respect to such claims.

(3) Notwithstanding subparagraph (2) above, the internal claims and Appeals process with respect to claims under the medical Benefit Feature will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant, so long as the Claims Supervisor demonstrates that the violation was for good cause or due to matters beyond the control of the Claims Supervisor and that the violation occurred in the context of an ongoing, good faith exchange of information between the Claims Supervisor and the Claimant. This exception is not available if the violation is part of a pattern of violations by the Claims Supervisor. The Claimant may request a written explanation of the violation from the Claims Supervisor, and the Claims Supervisor shall provide such explanation within ten (10) days, including a specific description of its basis, if any, for asserting that the violation should not cause the process outlined in Section 11.03(a) through (i) to be deemed exhausted. If the IRO or a court rejects the Claimant's request for immediate review due to deemed exhaustion on the basis that the Claims Supervisor met the standards for the exception described in this subsection, the Claimant shall have the right to resubmit and pursue the internal Appeal of the medical Benefit Feature claim. In such case, within a reasonable time after the IRO or court rejects the claim for immediate review (not to exceed ten (10) days), the Claims Supervisor shall provide the Claimant with notice of the opportunity to resubmit and pursue the internal Appeal of the medical Benefit Feature claim. Time periods for re-filing the medical Benefit Feature claim shall begin to run upon the Claimant's receipt of such notice.

Section 11.06. Effect of Federal Guidance on Medical Benefit Feature Claims and Appeal Review. Any information, processes, standards of review, or other elements that are required to be provided under Section 11.03 with respect to claims under the medical Benefit Feature shall be provided or applied only if the medical Benefit Feature is required to do so under applicable law, and the U.S. Departments of Labor, Treasury, and Health and Human Services are currently enforcing such requirements. For these purposes the Plan may rely fully on the U.S. Department of Labor Technical Release 2011-01, the U.S. Department of Labor Technical Release 2011-02, the June 24, 2011 amendment to the interim final regulations published July 23, 2010, and any subsequent guidance.

ARTICLE XII.
SUBROGATION AND REIMBURSEMENT RIGHTS

Section 12.01. 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 12.02. 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 12.03. 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 12.02 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 12.04. 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 12.05. 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 12.06. 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 12.07. 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 12.01 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 12.08. 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 12.09. 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 12.10. 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 12.11. Future Claims Excluded. If the Covered Person receives any sum of money described in Section 12.02 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 12.12. 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 XIII.
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 XIV.
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 14.01. 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 Employee, Eligible Retiree, Dependent, or beneficiary shall be subject to any debt, liability, contract, engagement, or tort of any Eligible Employee, 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 14.02. Additional Taxes or Penalties. If there are any taxes or penalties payable by the University on behalf of any Eligible Employee or Eligible Retiree, such taxes or penalties shall be payable by the Eligible Employee or Eligible Retiree to the University to the extent such taxes would have been originally payable by the Eligible Employee or Eligible Retiree had this Plan not been in existence.

Section 14.03. 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 Employee or Eligible Retiree under the Plan shall be excludable from the Eligible Employee's or 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 Employee or Eligible Retiree. It shall be the obligation of each Eligible Employee and Eligible Retiree to determine whether payment under the Plan is excludable from the Eligible Employee's or 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 Employee or Eligible Retiree has reason to believe that any such payment is not excludable.

Section 14.04. 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 14.05. 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 14.06. 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 Employee or Eligible Retiree, when addressed to the Eligible Employee or Eligible Retiree at his or her address as it appears in the records of the Administrator or the Claims Supervisor.

Section 14.07. Disclaimer of Liability. Nothing contained herein shall confer upon an Eligible Employee or 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 14.08. 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 Employee or Eligible Retiree, then the University, the Administrator, or the Claims Supervisor may deduct it when making future payments directly to that Eligible Employee or Eligible Retiree.

Section 14.09. 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 14.10. 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 14.11. 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 14.12. 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 14.13. Receipt and Release. Any payments to any Eligible Employee or Eligible Retiree shall, to the extent thereof, be in full satisfaction of the claim of such Eligible Employee or Eligible Retiree being paid thereby, and the Administrator may condition payment thereof on the delivery by the Eligible Employee or Eligible Retiree of the duly executed receipt and release in such form as may be determined by the Administrator.

Section 14.14. 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 14.15. 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 14.16. 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 14.17. Misrepresentation. Any material misrepresentation on the part of the Eligible Employee or 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 14.18. 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 Employee or Eligible Retiree, and each child of the Eligible Employee or 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 Employee or 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 14.19. 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: _____

Print Name: Brad Kelsheimer

Title: Vice President for Finance and Administratio

Date August 7, 2014

SCHEDULE A

INSURED BENEFITS

Benefit Feature	Insurance Company/ Vendor	Contract/Policy Number
Basic Group Life and Accidental Death and Dismemberment	Sun Life Financial	202003
Voluntary Life, Dependent Life Insurance, and Accidental Death and Dismemberment	Sun Life Financial	202003
Long Term Disability	Sun Life Financial	202003
Group Dental Plan	Delta Dental	0210-0001 (actives) 0210-0099 (COBRA)
Group Vision Plan	Anthem Blue Cross Blue Shield	9695891

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 Employees 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: _____

Print Name: Brad Kelsheimer

Title Vice President for Finance and Administration

Date August 7, 2014

SCHEDULE B

UNINSURED BENEFITS

Benefit Feature	Claims Supervisor	Contract Number
Group Medical Plan – • PPO option • High Deductible Health Plan option (including medical/surgical, prescription drug, mental health and substance abuse benefits, and wellness benefits)	Anthem Blue Cross Blue Shield	**00228614**
DePauw University Flexible Spending Plan (including health care and dependent care flexible spending accounts)	HR Pro	N/A
Employee Assistance Program	CIGNA Behavioral Health	2234

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 Employees and/or 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: Brad A. Kelsheimer

Print Name: Brad Kelsheimer

Title Vice President for Finance and Administration

Date August 7, 2014

SCHEDULE C

BENEFIT PLAN AND CONTRACTS

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

1. The Sun Life Financial Basic Life Policies, Accidental Death and Dismemberment Policies, Voluntary Life Policy, Dependent Life Policy, and Long Term Disability Policy and all riders thereto.

2. The Delta Dental Insurance Policy and all riders thereto.

3. The Anthem Vision Plan Insurance Policy and all riders thereto.

4. The Group Health Plan for Employees of DePauw University and all amendments thereto.

5. The DePauw University Flexible Spending Plan and all amendments thereto.

6. CIGNA Behavioral Health Employee Assistance Program.

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: Brad A. Kelsheimer

Print Name: Brad Kelsheimer

Title Vice President for Finance and Administrati

Date August 7, 2014