

BROWN UNIVERSITY
HEALTH AND WELFARE PLAN

As Amended and Restated

Effective As of January 1, 2021

BROWN UNIVERSITY
HEALTH AND WELFARE PLAN
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BROWN UNIVERSITY

HEALTH AND WELFARE PLAN

Brown University (the “Employer”) hereby amends and restates the Brown University Health and Welfare Plan (the “Plan”), effective as of January 1, 2021. This document, together with the Exhibits and Appendices attached hereto, supersedes any prior version of this Plan set forth in any summary plan description, related insurance and administrative contracts and any other documents.

ARTICLE I

PURPOSE

The purpose of the Plan is to provide to Participants, and their Spouses, Dependents, and Beneficiaries, certain welfare benefits described herein. The Plan provides benefits through several Welfare Programs. Each Welfare Program is described in a summary plan description, a certificate of insurance booklet issued by an insurance company or other governing document (the “Governing Documents”). This Plan and the applicable Governing Documents for the Welfare Programs together constitute a single plan for all purposes under ERISA, and each of the Welfare Programs shall not be treated as a separate and distinct plan, but rather shall be treated as a separate benefit structure within this Plan.

There are no specific benefits provided in this Plan document. Rather, all of the welfare benefits provided hereunder are set forth in the Welfare Program. Accordingly, all of the terms and provisions of each of the Welfare Programs, including but not limited to the eligibility, participation, benefits and contribution provisions, as the same may be modified from time to time as provided for in each of the Welfare Programs, that are not inconsistent with the terms and conditions set forth in this Plan, shall be incorporated herein by reference and shall be of the same force and effect under this Plan as if they were fully set forth herein.

In the event that the provisions of any Welfare Program conflict with or contradict the provisions of this Plan or any other Welfare Program, the Plan Administrator shall use its discretion to interpret the terms and purpose of the Plan so as to resolve any conflict or contradiction. However, the terms of this document may not enlarge the rights of a Participant, Spouse, Dependent or Beneficiary to benefits available under any Welfare Program.

ARTICLE II

DEFINITIONS

2.1 “Beneficiary” means beneficiary as defined under a Welfare Program.

2.2 “Claims Administrator” means (i) as to any Welfare Program which is self-insured by the Company, the Plan Administrator or its designee and (ii) as to any Welfare Program that is insured, the respective insurer or its designee.

2.3 “Code” means the Internal Revenue Code of 1986, as amended from time to time.

2.4 “Dependent” means dependent as defined under a Welfare Program. However, for purposes of any group health plan listed in Appendix A that provides medical benefits and other Welfare Programs identified in Appendix A as defining Dependent in the same manner as the group health plan that provides medical benefits, a Dependent shall include Participant’s eligible children who have not attained age 26 (or such later age as determined by the Plan Administrator).

2.5 “Effective Date” initially means January 1, 2021.

2.6 “Employee” means any person providing services to the Employer as a common-law employee and who is identified in one or more of the Appendices as eligible to participate in a Welfare Program. Independent contractors (even if re-characterized by the Internal Revenue Service as employees), leased employees within the meaning of Sections 414(n)(2) and 414(o)(2) of the Code, and individuals designated by the Employer as temporary employees shall not be Employees for purposes of this Plan.

2.7 “Employer” means Brown University and any entity which succeeds to the business and assumes the obligations of the Employer hereunder.

2.8 “ERISA” means the Employee Retirement Income Security Act of 1974, as amended.

2.9 “Former Employee” means any person formerly employed as an Employee.

2.10 “Governing Documents” means any summary plan description, certificate of insurance booklet issued by an insurance company or other governing document that describes and governs each Welfare Program.

2.11 “Health Insurance Buyout” or “Buyout” means a taxable cash payment available to certain eligible Employees described in Appendix B who decline health coverage through Brown University and provide evidence that they have health insurance through another source (such as a spouse’s employer) that is primary to Medicare. The amount of the Health Insurance Buyout is based on the number of hours that the eligible Employee is scheduled to work each Plan Year, is determined prior to each Plan Year, and shall remain in effect for the entire Plan Year.

2.12 “Participant” means any Employee or Former Employee who satisfies the requirements of Article III of the Plan and whose participation has not terminated in accordance with Section 3.3.

2.13 “Participant Contribution” means the pre-tax or after-tax contribution required to be paid by a Participant, if any, as determined under each Welfare Program. The term “Participant Contribution” includes contributions used for the provisions of benefits under a self-insured arrangement of the Employer as well as contributions used to purchase insurance contracts or policies.

2.14 “Plan” means the Brown University Health and Welfare Plan, as set forth herein, and each Welfare Program incorporated hereunder by reference, as amended from time to time.

2.15 “Plan Administrator” means the Employer or such other individual, committee or firm as the Employer shall designate from time to time.

2.16 “Plan Year” means the twelve (12) consecutive month period beginning January 1 and ending December 31.

2.17 “Spouse” means spouse as defined under a Welfare Program.

2.18 “Welfare Program” means a written arrangement incorporated into this Plan that is offered by the Employer which provides an employee benefit that would be treated as an “employee welfare benefit plan” under Section 3(1) of ERISA if offered separately. Welfare Program also means any plan established pursuant to Section 125 or Section 132(f) of the Code. Each Welfare Program under the Plan is identified in Appendix A which is incorporated into and made a part of the Plan. The Employer may add or delete a Welfare Program from the Plan by amending Appendix A without any need to otherwise amend the Plan. Amendment of Appendix A may be made by any authorized officer or representative of the Employer and shall not require approval by the Employer’s Board of Trustees.

ARTICLE III

ELIGIBILITY AND PARTICIPATION

3.1 Eligibility. An Employee shall be eligible to participate in the Plan only if and to the extent the Employee is eligible with respect to the relevant Welfare Programs specified in Appendix A and as set forth in Appendix B unless stated otherwise in the Welfare Program documents. The Welfare Programs also designate those Spouses, Dependents, or Beneficiaries, if any, eligible to receive benefits from the Plan and set forth the criteria for their becoming covered hereunder. The effective date of participation and the terms of participation shall be determined under the terms and provisions of each Welfare Program.

3.2 Enrollment. The Plan Administrator shall establish procedures in accordance with the Welfare Programs for the enrollment of eligible Employees, their Spouses or Dependents, if any, under the Plan. The Plan Administrator shall prescribe enrollment forms that must be completed by a prescribed deadline prior to commencement of coverage under the Plan.

3.3 Termination of Participation. A Participant shall cease being a Participant in the Plan, and coverage under this Plan for the Participant, his Spouse, Dependents and Beneficiaries, if any, shall terminate, in accordance with the provisions of the Welfare Programs.

3.4 Eligibility for Rehires. An Employee who is rehired by the Employer or Participating Employer within 30 calendar days of termination is eligible on the first day of the month on or after his date of rehire for the same benefits he had upon termination of employment from the Employer or Participating Employer. If, however, the Employee is rehired more than 30 calendar days following termination of employment from the Employer or Participating Employer, such Employee may elect benefits as if newly hired.

ARTICLE IV

FUNDING AND BENEFITS

4.1 Funding. (a) Notwithstanding anything to the contrary contained herein, participation in the Plan and the payment of Plan benefits attributable to Employer contributions shall be conditioned on a Participant contributing to the Plan at such time and in such amounts as the Plan Administrator shall establish from time to time. The Plan Administrator may require that any Participant Contributions be made by payroll deduction. Nothing herein requires the Employer or the Plan Administrator to contribute to or under any Welfare Program, or to maintain any fund or segregate any amount for the benefit of any Participant or his Spouse, Dependent or Beneficiary, except to the extent specifically required under the terms of a Welfare Program. No Participant, Spouse, Dependent or Beneficiary shall have any right to or interest in, the assets of the Employer or Participating Employer.

(b) The Employer shall have no obligation, but shall have the right, to insure or reinsure, or to purchase stop loss coverage with respect to any Welfare Program under this Plan. To the extent the Employer elects to purchase insurance with respect to any Welfare Program, any benefits to be provided under such Welfare Program shall be the sole responsibility of the insurer, and the Employer and any Participating Employer shall have no responsibility for the payment of such benefits (except for refunding any Participant Contributions that were not remitted to the insurer).

4.2 Benefits. Coverage for benefit claims incurred on or after the Effective Date by a Participant or his or her eligible Dependent shall be as provided in the Welfare Programs attached hereto and made a part hereof. The provisions of the Welfare Programs are hereby incorporated by reference and made a part hereof for purposes of determining the benefits provided to or on behalf of a Participant or his or her eligible Dependents. The rights and conditions with respect to the benefits payable pursuant to each Welfare Program shall be determined exclusively from such Welfare Program providing for the payment of benefits hereunder, notwithstanding any inconsistent oral or written statements of any person or entity.

ARTICLE V

ADMINISTRATION AND FIDUCIARY PROVISIONS

5.1 Named Fiduciary. The Plan Administrator shall be the “named fiduciary” of the Plan, as defined in Section 402(a)(2) of ERISA, unless the Employer appoints a replacement.

5.2 Plan Administration. Except as otherwise provided in a Welfare Program:

(a) The Plan Administrator shall have sole discretion and authority to control and manage the operation and administration of the Plan.

(b) The Plan Administrator shall have complete discretion to interpret the provisions of the Plan, determine eligibility, make findings of fact, correct errors, and supply omissions. All decisions and interpretations of the Plan Administrator made in good faith pursuant to the Plan shall be final, conclusive and binding on all persons, subject only to the

claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious.

(c) The Plan Administrator shall have all other powers necessary or desirable to administer the Plan, including, but not limited to, the following:

(i) To prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan;

(ii) To prepare and distribute information explaining the Plan to Participants;

(iii) To receive from the Employer, Participants, Spouses, Dependents and Beneficiaries such information as shall be necessary for the proper administration of the Plan;

(iv) To keep records of elections, claims, disbursements for claims under the Plan, and any other information required by ERISA or the Code;

(v) To appoint individuals or committees to assist in the administration of the Plan and to engage any other agents it deems advisable;

(vi) To purchase any insurance deemed necessary for providing benefits under the Welfare Programs;

(vii) To accept, modify or reject Participant elections under the Plan;

(viii) To promulgate election forms and claims forms to be used by Participants;

(ix) To prepare and file any reports or returns with respect to the Plan required by the Code, ERISA or any other laws;

(x) To determine and announce any Participant Contributions required under the Welfare Programs;

(xi) To determine and enforce any limits on benefits elected under the Welfare Programs;

(xii) To take such action as may be necessary to cause any required payroll deduction of any Participant Contributions required under the Welfare Programs; and

(xiii) To correct errors and make equitable adjustments for mistakes made in the administration of the Plan; specifically, and without limitation, to recover erroneous overpayments made from the Plan to a Participant, his Spouse, Dependent or Beneficiary, in whatever manner the Plan Administrator determines is appropriate, including recoupment of past payments or suspensions of, or offsets against, future payments due that Participant, Spouse, Dependent or Beneficiary.

5.3 Delegation of Duties. The Plan Administrator shall have the authority to allocate or delegate, from time to time, in writing, all or any part of its responsibilities under the Plan to such person or persons as the Plan Administrator may deem advisable and may revoke any such allocation or delegation of responsibility. Any action of such person in the exercise of such allocated or delegated responsibilities shall have the same force and effect for all purposes hereunder as if such action had been taken by the Plan Administrator. The Plan Administrator shall not be liable for any actions or omissions of any delegate. The delegate shall report periodically to the Plan Administrator concerning the discharge of the allocated or delegated responsibility.

5.4 Indemnification. The Plan Administrator and any delegate who is an employee of the Employer or Participating Employer shall be fully indemnified by the Employer against all liabilities, costs, and expenses (including defense costs, but excluding any amount representing a settlement unless such settlement is approved by the Employer) imposed upon it in connection with any action, suit, or proceeding to which it may be a party by reason of being the Plan Administrator or having been assigned or delegated any of the powers or duties of the Plan Administrator, and arising out of any act, or failure to act, that constitutes or is alleged to constitute a breach of such person's responsibilities in connection with the Plan, unless such act or failure to act is determined to be due to gross negligence or willful misconduct.

5.5 Compensation and Expenses of Plan Administrator. The Plan Administrator shall serve without compensation for services as such. All expenses of the Plan shall be paid by the Employer.

5.6 Outside Assistance. The Plan Administrator may refer technical questions to insurance claims administrators, consultants, attorneys, medical professionals or others, as the Plan Administrator deems necessary for the proper administration of the Plan.

ARTICLE VI

CLAIMS AND SUBROGATION

6.1 Claims Procedure. (a) A claim for benefits under a Welfare Program shall be submitted and processed in accordance with the procedures of each Welfare Program; provided however that to the fullest extent possible as to each Welfare Program, each Participant shall have a right to procedures which are in compliance with applicable law and accordingly, all procedures shall be deemed to be modified when and as needed to comply with the requirements of applicable law. To the extent a Welfare Program does not have legally compliant procedures, the procedures contained in this Article VI shall apply.

(b) A request for benefits is a "claim" subject to these procedures only if it is filed by the Participant or the Participant's authorized representative in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable Welfare Program provider. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator. A request for prior approval of a benefit or service where prior approval is not required under the

Plan is not a “claim” under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a “claim” under these rules, unless it is determined that the inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to process the claim, the Participant will be given an opportunity to provide the missing information.

(c) Participants may designate an authorized representative if written notice of such designation is provided to the applicable provider identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of the Participant’s medical condition may act as an authorized representative with or without prior notice.

6.2 Claims Procedures for Group Health Plans. (a) This Section is intended to comply with Department of Labor Regulations 2560.503-1 and 2590.715-2719, and shall apply specifically to claims under a group health plan as defined in Department of Labor Regulation 2560.503-.1. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for the Welfare Program, the claims procedure in such other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure, provided such other claims procedure complies with Department of Labor Regulations 2560.503-1 and 2590.715-2719.

(b) Written Claim for Benefits. If a claimant asserts a right to any benefit under the Plan, the claimant must file a written claim for such benefit with the Plan Administrator. For purposes of this Section, claimant shall mean any Participant, Spouse, Dependent, Beneficiary or authorized representative who files a claim for group health plan benefits under the Plan.

(c) Benefit Determinations.

(i) Post-Service Claims. A post-service claim is any claim that is filed for payment of benefits after health care has been received.

(A) Upon the denial of a post-service claim, the Plan Administrator shall notify the claimant in writing of such denial within 30 days after the Plan’s receipt of the claim. The Plan Administrator shall be permitted one 15-day extension to the 30-day claim determination period, provided that the Plan Administrator determines that such extension is necessary due to matters beyond the Plan’s control and notifies the claimant before the end of the initial 30-day period of the circumstances necessitating the extension of time and the date by which the Plan intends to render a decision. If such extension is required due to the claimant’s failure to submit all information necessary to decide the claim, the extension notification must specifically describe the required information and the claimant shall have 45 days from receipt of the notice to provide the requested information. Failure by the claimant to provide requested information shall result in the denial of the claim.

(B) A denial notice shall (i) explain the reason(s) for denial, (ii) refer to the Section(s) of the Plan on which the denial is based, (iii) provide a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary, (iv) provide the claim appeal procedures, including a statement of the claimant's right to bring a civil action under ERISA following an adverse benefit determination on review of an appeal, (v) if applicable, include a copy of the internal rule, guideline or protocol that was relied upon to make the adverse determination, or a statement that such rule was relied upon and that a copy of such rule will be provided free of charge to the claimant upon request; and (vi) if the adverse determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge to the claimant upon request. The denial notice must also comply with any additional requirements described in Department of Labor Regulation 2590.715-2719.

(C) The time period to consider a post-service claim shall be suspended from the date any notification of extension is sent to the claimant until the claimant fulfills any request for additional information.

(ii) Pre-Service Claims. A pre-service claim is any claim for benefits that requires certification or approval prior to the performance of the requested health care service.

(A) Upon receiving a pre-service claim, the Plan Administrator shall notify the claimant in writing of the Plan's benefit determination (whether adverse or not) within a reasonable period but no later than 15 days after receipt of the claim. The Plan Administrator shall be permitted one 15-day extension provided that the Plan Administrator determines that such extension is necessary due to matters beyond the Plan's control and notifies the claimant before the end of the initial 15-day period of the circumstances necessitating the extension of time and the date by which the Plan intends to render a decision. The Plan Administrator shall, within five days of receiving any deficient claim, notify the claimant of such deficiency and the steps necessary to correct the claim. Notification may be oral unless the claimant requests written notification. The claimant shall have 45 days from receipt of the notice to provide the requested information. Failure by the claimant to provide requested information shall result in the denial of the claim.

(B) A denial notice shall (i) explain the reason(s) for the denial, (ii) refer to the Section(s) of the Plan on which the denial is based, (iii) provide a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary, (iv) provide the claim appeal

procedures, including a statement of the claimant's right to bring a civil action under ERISA following an adverse benefit determination on review of an appeal, (v) if applicable, include a copy of the internal rule, guideline or protocol that was relied upon to make the adverse determination, or a statement that such rule was relied upon and that a copy of such rule will be provided free of charge to the claimant upon request; and (vi) if the adverse determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge to the claimant upon request. The denial notice must also comply with any additional requirements described in Department of Labor Regulation 2590.715-2719.

(C) The time period to consider a pre-service claim shall be suspended from the date any notification of extension is sent to the claimant until the claimant fulfills any request for additional information.

(iii) **Urgent Care Claims.** An urgent care claim is a claim that requires notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize the claimant's life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of the claimant's health condition, could cause severe pain.

(A) An urgent care claimant shall receive notice of the benefit determination (whether adverse or not) in writing or electronically as soon as possible taking into account the medical situation, but no later than 72 hours after the Plan's receipt of the claim (or such other time as prescribed in Department of Labor Regulation 2590.715-2719). If the claimant files an urgent care claim improperly, the Plan Administrator shall notify the claimant of the improper filing and how to correct it as soon as possible but not later than 24 hours after the Plan's receipt of the claim. The claimant shall have 48 hours to provide the requested information and shall be notified of a determination no later than 48 hours (or such other time as prescribed in Department of Labor Regulation 2590.715-2719) after receipt of the corrected claim or the end of the 48-hour period afforded to the claimant to provide the requested additional information.

(B) A denial notice shall (i) explain the reason(s) for the denial, (ii) refer to the Section(s) of the Plan on which the denial is based, (iii) provide a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary, (iv) provide the claim appeal procedures, including a statement of the claimant's right to bring a civil action under ERISA following an adverse benefit determination on review of an appeal, (v) if applicable, include a copy of the internal rule, guideline or protocol that was relied upon to make the adverse determination, or a statement that such rule was relied upon and that a copy of such rule will

be provided free of charge to the claimant upon request; (vi) if the adverse determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge to the claimant upon request and (vii) include a description of the expedited review process applicable to claims involving urgent care. The denial notice must also comply with any additional requirements described in Department of Labor Regulation 2590.715-2719.

(iv) Concurrent Care Claims.

(A) Any request by a claimant to extend an on-going course of treatment beyond a previously approved specified period of time or number of treatments, that is an urgent care claim as defined in paragraph (iii) shall be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator shall notify the claimant of the benefit determination (whether adverse or not), within 24 hours of receipt of the claim, provided the claim is made at least 24 hours prior to the end of the approved period of time or number of treatments. If the claimant's request for extended urgent care treatment is not made at least 24 hours prior to the end of the approved treatment, the request shall be treated as an urgent care claim in accordance with paragraph (iii).

(B) If an ongoing course of treatment was previously approved for a specified period of time or number of treatments, and the claimant's request to extend treatment is non-urgent, the claimant's request shall be considered a new claim and decided in accordance with post-service or pre-service timeframes, as applicable,

(d) Appeal of Claim Denial.

(i) Any claimant shall have the right to appeal an "adverse benefit determination" as defined in Department of Labor Regulation 2590.715-2719 within 180 days of receipt of such adverse benefit determination. Failure to appeal within such 180-day period will be deemed to be a failure to exhaust all administrative remedies under the Plan. Any appeal shall be submitted to the Plan Administrator in writing. If the appeal relates to a claim for payment, the claimant's request should include: the patient's name and plan identification number; the date(s) of health care service(s); the provider's name; the reason(s) the claimant believes the claim should be paid; and any documentation or other written information to support the claimant's request for claim payment.

(ii) An appeal shall be determined by an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor a subordinate of that individual. If the appeal is related to medical matters, the appeal shall be reviewed in consultation with an independent and impartial health care professional who has appropriate training and experience in the particular field of medicine in order to make the health

care judgment and who was not involved in the prior determination. The Plan Administrator may consult with, or seek the participation of, independent and impartial medical experts as part of the appeal resolution process. The claimant consents to this referral and the sharing of pertinent health claim information. Upon request and free of charge the claimant has the right to reasonable access to and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

(iii) Upon being notified of an adverse determination under an appeal, the claimant shall be permitted, within 60 days of receiving notice of such determination, to submit notice of a "second-level appeal" to the Plan Administrator. A second-level appeal shall be decided in accordance with the rules in paragraph (ii).

(e) Timeframes for Appeals Determinations.

(i) Pre-Service Claim Appeal. The Plan Administrator shall have 15 days, upon receiving notice of appeal (or second-level appeal) of the denial of benefits under a pre-service claim, to notify the claimant electronically or in writing of the appeal determination.

(ii) Post-Service Claim Appeal. The Plan Administrator shall have 30 days, upon receiving notice of appeal (or second-level appeal) of the denial of benefits under a post-service claim, to notify the claimant electronically or in writing of the appeal determination.

(iii) Urgent Care Claim Appeal. Upon receiving a notice to appeal (or second-level appeal) the determination of a claim involving urgent care, the Plan Administrator shall notify the claimant of the appeal determination as soon as possible, taking into account medical exigencies surrounding the claim, but no later than 72 hours (or such other time as prescribed in Department of Labor Regulation 2590.715-2719). Notice shall be given to the claimant by telephone, facsimile, or other similarly expeditious manner. Oral communications shall be followed up in writing.

(iv) The Plan Administrator has the exclusive right to interpret and administer the provisions of the Plan and its decisions with respect to claims are conclusive and binding.

(f) Content of Notice of Appeals Decisions. The Plan Administrator shall provide a written or electronic notice of the determination on review of an appeal of an adverse benefit determination in accordance with applicable Department of Labor regulations. The denial notice shall (i) explain the reason(s) for the denial, (ii) refer to the Section(s) of the Plan on which the denial is based, (iii) include a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all relevant documents relied upon by the Plan Administrator in making the benefit determination, (iv) provide the claim appeal procedures, including a statement of the claimant's right to bring a civil action under ERISA following an adverse benefit determination on review of an appeal, (v) if applicable, include a copy of the internal rule, guideline or protocol that was relied upon to make the adverse determination, or a statement that such rule was relied upon and that a copy of such rule will be provided free of charge to the claimant upon request; (vi) if the adverse determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of

the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge to the claimant upon request and (vii) include a description of the expedited review process applicable to claims involving urgent care.

(g) External Appeals.

Except as otherwise required by applicable law, if a Participant exhausts all internal appeals procedures, the Participant may commence an external review. The external review process will comply with applicable state or federal law and other rules and procedures for non-Grandfathered Plans as prescribed in Department of Labor Regulation 2590.715-2719.

6.3 Claims Procedure for Benefits Based on Determination of Disability. (a) This Section shall apply to any claim made under a Welfare Program which bases benefits on a determination of disability. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for the Welfare Program, the claims procedure in such other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure as long as such other claims procedure complies with Department of Labor Regulation 2560.503-1.

(a) If a claim for benefits based on a determination of disability is denied in whole or in part, the claimant or the claimant's Beneficiary shall receive written notification within a reasonable period of time, but no later than 45 days after the Plan Administrator's receipt of the claim. The Plan Administrator may extend this period for up to 30 additional days provided the Plan Administrator determines that the extension is necessary due to matters beyond the Plan Administrator's control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date by which the Plan Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Plan Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. Any notice of extension must be sent to the claimant before the end of the initial 30-day period, and shall explain the circumstances requiring the extension, the date by which the Plan Administrator expects to render a decision, the standards on which the claimant's entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, the claimant must submit. The claimant shall be provided with at least 45 days to provide the additional information. The period from which the claimant is notified of the additional required information to the date the claimant responds is not counted as part of the determination period.

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

(c) The time period to consider a claim for benefits based on a determination of disability or to consider an appeal of an adverse benefit determination shall be suspended from the date any notification of extension is sent to the claimant or appellant until such individual fulfills such request for additional information.

6.4 Claims Procedure for Benefits Other Than Health Benefits or Those Based on Determination of Disability.

(a) If the Welfare Program does not describe a claims procedure for benefits that satisfies the requirements of Section 503 of ERISA, or the Plan Administrator determines that the procedures described in Sections 6.2 or 6.3 with respect to a particular Welfare Program shall not apply, the claims procedure described in this Section shall apply with respect to such Welfare Program if the Welfare Program is subject to ERISA. If the Welfare Program is not subject to ERISA as determined by the Plan Administrator, then the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for the Welfare Program shall supersede this procedure.

(b) If a Participant or former Participant asserts a right to any benefit under the Plan that he has not received, he or his authorized representative shall file a written claim for such benefit with the Plan Administrator. If the Plan Administrator wholly or partially denies such claim, it shall provide written or electronic notice to the claimant within a reasonable period of time, but not later than 90 days after receipt by the Plan Administrator of the claim, unless the Plan Administrator determines that special circumstances require an extension of time, not to exceed 90 days, for processing the claim. If the Plan Administrator determines that an extension of time is required, it shall provide the claimant with written notice of the extension before the end of the initial 90-day period. Such notice shall describe the special circumstances requiring the extension of time and specify the date by which the Plan Administrator expects to render a benefit determination. If the Plan Administrator wholly or partially denies a claim, it shall set forth in its benefit determination, which shall be written in a manner calculated to be understood by the claimant:

- (i) the specific reasons for the denial of the claim;
 - (ii) specific reference(s) to pertinent provisions of the Plan on which the adverse benefit determination is based;
 - (iii) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
 - (iv) an explanation of the Plan's claims review procedure, including the time limits applicable under such procedure; and
 - (v) a statement that the claimant has the right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.
- (c) A Participant or former Participant whose claim for benefits is denied may request a full and fair review of the adverse benefit determination within 60 days after

notification of the adverse benefit determination by the Plan Administrator. The Participant or former Participant:

(i) shall be provided a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial determination;

(ii) shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim; and

(iii) may submit written comments, documents, records and other information relating to the claim to the Plan Administrator for review.

(d) Subject to Section 2560.503-1(i)(1)(ii) of the Department of Labor regulations, a decision on review by the Plan Administrator shall be made within a reasonable period of time, but not later than 60 days after receipt by the Plan Administrator of a request for review, unless special circumstances (such as the need to hold a hearing) require an extension of time for processing, in which case the claimant shall be provided with written notice of the extension before the end of the initial 60-day period. Such notice shall describe the special circumstances requiring the extension and specify the date by which the Plan Administrator expects to render its decision. In no event shall the decision be rendered later than 120 days after receipt of the request for review.

(e) The Plan Administrator shall provide written or electronic notice of its decision with respect to the claimant's appeal which shall be written in a manner calculated to be understood by the claimant. If there is an adverse benefit determination on review, the Plan Administrator's decision shall include:

(i) the specific reasons for the adverse benefit determination;

(ii) specific reference(s) to pertinent provisions of the Plan on which the adverse benefit determination is based;

(iii) 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 claim;

(iv) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to receive information about any such procedures; and

(v) a statement that the claimant has the right to bring a civil action under Section 502(a) of ERISA following the adverse benefit determination on review.

6.5 Unclaimed Benefits. If, within one year after any amount becomes payable hereunder to a Participant, Spouse, Dependent or Beneficiary and the same shall not have been claimed or any check issued under the Plan remains uncashed, provided reasonable care shall

have been exercised by the Plan Administrator in attempting to make such payments, the amount thereof shall be forfeited and shall cease to be a liability of the Plan.

6.6 Right of Subrogation.

(a) Definitions. For purposes of this Section, the following definitions shall apply:

(i) Award. “Award” means any amount paid to or on behalf of a Covered Individual, from a Third Party with respect to a Covered Individual’s Illness, Injury or other loss regardless of whether such amount is received as a result of a judgment of a court of competent jurisdiction, settlement, compromise or otherwise and regardless of whether such amount is categorized as punitive, compensatory, reimbursement for medical expenses, or otherwise.

(ii) Covered Individual. “Covered Individual” includes the individual for whom benefits are paid by the Plan and his or her heirs, guardians, executors or other representatives.

(iii) Injury or Illness. “Injury” or “Illness” means such term as defined in each Welfare Program.

(iv) Reimbursement. “Reimbursement” means the Plan’s right to recover any and all amounts paid for medical expenses from a Covered Individual who receives any award related to the Illness, Injury or other loss that resulted in the payment of such benefits by the Plan.

(v) Subrogation. “Subrogation” means the right of the Plan. to be substituted in place of any Covered Individual with respect to that Covered Individual’s lawful claim, demand, or right of action against a Third Party who may have wrongfully caused the Covered Individual’s Injury, Illness or other loss that resulted in a payment of benefits by the Plan.

(vi) Third Party. “Third Party” includes, but is not limited to, any person or entity that caused, contributed to, or may be responsible for the Injury, Illness or other loss to the Covered Individual. Third Party shall include any party, such as an insurance company, that acquires or may acquire responsibility through the actions of such person or entity and shall also include uninsured motorist coverage.

(b) Subrogation, Reimbursement and Benefit Offsets. For any and all benefit paid by the Plan to or on behalf of a Covered Individual by reason of Illness, Injury or other loss the Plan shall have the following rights:

(i) Subrogation to any and all rights of recovery the Covered Individual may have arising from such Injury, Illness or other loss;

(ii) Reimbursement for the amount of any and all benefits paid to or on behalf of the Covered Individual by reason of Injury, Illness or other loss with respect to which

the Plan has a right to subrogation pursuant to paragraph (i) above from any award arising out of such Injury, Illness or other loss; and

(iii) Benefit offsets of future claims payable by the Plan on behalf of the Covered Individual or members of such Covered Individual's immediate family to recover any and all amounts paid to or on behalf of the Covered Individual by reason of such Illness, Injury or other loss with respect to which the Plan has a right to subrogation pursuant to paragraph (i) and a right to reimbursement pursuant to paragraph (ii) but which have not, for any reason whatsoever, been reimbursed to or recovered by the Plan.

The Plan's subrogation/reimbursement/benefit offset rights (herein referred to collectively as "Recovery Rights") shall include the right to recover the amount due and owing to the Plan pursuant to its Recovery Rights from any award paid to or for the benefit of the Covered Individual. The Plan does not recognize the "make whole" rule and a Covered Individual may not be whole after the Plan's Recovery Rights are satisfied.

(c) Payment Prior to Determination of Responsibility of a Third Party. The Plan does not cover nor is it liable for any expenses for services or supplies incurred by a Covered Individual for any Illness, Injury or other loss which a Third Party caused, contributed to or may be responsible for to the extent that the Covered Individual receives any award from any Third Party. However, subject to the terms and conditions of this Section, the Plan will, after receipt of an executed reimbursement/subrogation/assignment agreement on such form as the Plan Administrator may require, make advance payment of benefits in accordance with the terms of the Plan, until an award is paid to or for the benefit of the Covered Individual by a Third Party with respect to such Illness, Injury or loss. The terms and provisions of such reimbursement/ subrogation/assignment agreement are incorporated herein by reference and any such agreement shall constitute a part of the Plan.

By accepting an advance payment of benefits from the Plan, the Covered Individual(s) jointly and severally agree that:

(i) the Plan has a priority lien against any award paid to or on behalf of the Covered Individual to assure that reimbursement is promptly made; and

(ii) the Plan will be subrogated to such Covered Individual's right of recovery from any Third Party to the extent of the Plan's advance payment of benefits; and

(iii) such Covered Individual(s) will, jointly and severally, reimburse the Plan out of any and all awards paid or payable to such Covered Individual(s) by any Third Party to the extent of the Plan's advance payment of benefits for claims related to the Illness, Injury or other loss; and

(iv) such Covered Individual(s) will assign to the Plan all of their right, title and interest in and to any award paid to or on their behalf by any Third Party to the extent of any advance payment of benefits made or to be made in accordance with the terms of the Plan.

The Plan's Recovery Rights include but are not limited to all claims, demands, actions and rights of recovery of all Covered Individuals against any Third Party, including any

Workers' Compensation insurer or governmental agency, and will apply to the extent of any and all advance payment of benefits made or to be made by the Plan.

(d) Recovery Actions. The Plan may, at its discretion, start any legal action or administrative proceeding it deems necessary to protect its Recovery Rights, and may try or settle any such action or proceeding in the name of and with the full cooperation of the Covered Individual. However, in doing so, the Plan will not represent, or provide legal representation for, any Covered Individual with respect to such Covered Individual's damages to the extent those damages exceed any advance payment of benefits made or to be made in accordance with the terms of this Plan.

The Plan may, at its discretion, intervene in any claim, legal action, or administrative proceeding started by any Covered Individual against any Third Party on account of any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Individual's Illness, Injury or other loss that resulted in any advance payment of benefits by the Plan.

(e) Reimbursement/Subrogation/Assignment Agreement. . Prior to the advance payment of benefits for which a Third Party may be responsible, the Covered Individual on whose behalf an advance payment of benefits may be payable must execute and deliver any and all agreements, instruments and papers requested by or on behalf of the Plan including an executed reimbursement/subrogation/assignment agreement or such other form as the Plan Administrator may require. The failure of a Covered Individual to execute any such reimbursement/subrogation/assignment agreement or such other form as the Plan Administrator may require, for any reason, shall not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's Recovery Rights if the Plan, at its discretion, makes an advance payment of benefits for any reason in the absence of a reimbursement/subrogation/assignment agreement.

(f) Administrative Procedure. The Plan's standard administrative procedure will be to determine whether a Third Party could be held liable for a claim. Claims will not be paid until this determination is made. If it is determined that the claim may be the responsibility of a Third Party for any reason, the Plan will not process any claims without a properly signed reimbursement/subrogation/assignment agreement as described in this Section.

(g) Cooperation with the Plan by All Covered Individuals. By accepting an advance payment of benefits, the Covered Individual agrees not to do anything that will waive, compromise, diminish, release or otherwise prejudice the Plan's Recovery Rights and to do whatever is necessary to protect the Plan's Recovery Rights.

By accepting an advance payment for benefits the Covered Individual agrees to notify and consult with the Plan Administrator or its designee before:

(i) starting any legal action or administrative proceeding against a Third Party based on any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Individual's Illness, Injury or other loss that resulted in the Plan's advance payment for benefits; or

(ii) entering into any settlement agreement with a Third Party that may be related to any actions by the Third Party that may have caused or contributed to the Covered Individual's Illness, Injury or other loss that resulted in the Plan's advance payment for benefits related to such Illness, Injury or other loss.

Furthermore, by accepting an advance payment of benefits, the Covered Individual agrees to keep the Plan Administrator or its designee, informed of all material developments with respect to all such claims, actions or proceedings.

The Plan's Recovery Rights are Plan assets. The Plan or its designee may institute a lawsuit against a Covered Individual if such Covered Individual does not adequately protect the Plan's Recovery Rights.

(h) All Recovered Proceeds Are to be Applied to Reimburse the Plan. By accepting an advance payment of benefits for an Illness, Injury or other loss, the Covered Individual agrees to reimburse the Plan for all such advances from any award paid or payable to or on behalf of such Covered Individuals by any Third Party. In such event, the Plan must be fully reimbursed within 31 days or the Covered Individual will be liable for interest and all costs of collection, including reasonable attorney's fees.

If a Covered Individual fails to reimburse the Plan as required by this Section, the Plan may apply any future claims for benefits that may become payable on behalf of such Covered Individual or any member of such Covered Individual's immediate family to the amount not reimbursed.

Notwithstanding anything contained in the Plan to the contrary, the Plan will not pay future benefits for claims related to an Illness, Injury or other loss with respect to which an award was paid to or on behalf of a Covered Individual unless the Plan Administrator determines that the award was reasonable and the subsequent claims were not recognized in the award.

(i) Pre-Emption of State Law. To the extent that this Plan is a self-insured employee welfare benefit plan, ERISA preempts any state law purporting to limit, restrict or otherwise alter the Plan's Recovery Rights.

(j) No-Fault Insurance Coverage. Notwithstanding anything contained in the Plan to the contrary, if a Covered Individual is required to have no-fault automobile insurance coverage, the automobile no-fault insurance carrier will initially be liable for any and all expenses paid by this Plan up to the greater of:

(i) the maximum amount of basic reparation benefit required by applicable law, or

(ii) the maximum amount of the applicable no-fault insurance coverage in effect.

The Plan will, thereafter, consider any excess charges and expenses under the applicable provisions of this Plan in which the Covered Individual is provided coverage. Before related claims will be paid through the Plan, the Covered Individual will be required to sign a

reimbursement/subrogation/assignment agreement or such other form as the Plan Administrator may require.

If the Covered Individual fails to secure no-fault insurance as required by state law, the Covered Individual is considered as being self-insured and must pay the amount of any and all expenses paid by the Plan for any and all Covered Individuals arising out of the accident.

(k) Refund of Overpayment of Benefits - Right of Recovery. If the Plan pays benefits for expenses incurred on account of a Covered Individual, the Covered Individual or any other person or organization that was paid must make a refund to the Plan if:

(l) all or some of the expenses were not paid, or did not legally have to be paid by the Covered Individual;

(i) all or some of the payment made by the Plan exceeds the benefits under the Plan; or

(ii) all or some of the expenses were recovered from or paid by a source other than this Plan including another plan to which this Plan has secondary liability under the Coordination of Benefits provisions.

This may include payments made as a result of claims against a Third Party for negligence, intentional or otherwise wrongful acts or omissions. The refund shall equal the amount the Plan paid in excess of the amount it should have paid under the Plan. In the case of recovery from or payment by a source other than this Plan, the refund equals the amount of the recovery or payment up to the amount the Plan paid.

ARTICLE VII SPECIAL COMPLIANCE PROVISIONS

7.1 Use and Disclosure of Protected Health Information. This Section 7.1 contains the Plan provisions required by the Standards for Privacy of Individually Identifiable Health Information and for the security of Electronic Protected Health Information (45 C.F.R. § 164.102 *et seq.*), as amended from time to time, and any successor thereto (the “Privacy Rules”) and Security Standards for the Protection of Electronic Protected Health Information (45 C.F.R. § 164.302 *et seq.*), as amended from time to time, and any successor thereto (the “Security Rules”), each promulgated under Title II of the HIPAA, relating to the permitted disclosure of Protected Health Information by the Plan to the Employer. The provisions of this Section 7.1 shall apply to the Plan for so long as and to the extent that any portion of the Plan constitutes a “health plan” under HIPAA and, as such, is subject to the HIPAA Privacy Rules; provided, however, that the provisions of the Welfare Program documents governing any insured benefits that relate to the HIPAA Privacy Rules and Security Rules shall supersede any conflicting or inconsistent provisions of this Section 7.1.

Except as otherwise provided in this Section 7.1, the provisions of this Plan, including any definitions herein, shall apply to this Section 7.1; provided, however, that the provisions of this Section 7.1 shall supersede any conflicting or inconsistent provision of the Plan.

(a) Definitions. The following terms, when capitalized, will have the meanings set forth below for purposes of this Section 7.1, unless otherwise specified herein:

(i) “Breach” means the acquisition, access, use or disclosure of Unsecured Protected Health Information in a manner not permitted by the HIPAA Privacy Rules which compromises the security or privacy of the Protected Health Information (with certain exceptions for unintentional, inadvertent or good faith uses and disclosures described in 45 C.F.R. §164.402). Any use or disclosure not permitted by the Privacy Rules are presumed to be a breach unless the Plan or its business associate demonstrates, after performing risk analysis, that there is low probability that Unsecured Protected Health Information was compromised.

(ii) “Electronic Protected Health Information” means Protected Health Information that is maintained in, or transmitted by, electronic media (as defined in 45 C.F.R. § 160.103).

(iii) “Health Information” means any information, including genetic information, whether oral or recorded in any form or medium, that is created or received by the Plan and 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.

(iv) “Individually Identifiable Health Information” means Health Information, including demographic information, collected from an individual that identifies an individual; or with respect to which there is a reasonable basis to believe the information can be used to identify an individual.

(v) “Notice” means the notice of privacy practices for Protected Health Information required to be provided by the Plan to an individual enrolled in the Plan pursuant to the Privacy Rules.

(vi) “Plan Administration Functions” means administration functions performed by the Employer on behalf of the Plan, but excluding functions performed by the Employer in connection with any other benefit or Welfare Program of the Employer.

(vii) “Policies and Procedures” means the comprehensive privacy policies and procedures with respect to Protected Health Information established and maintained by the Plan pursuant to the Privacy Rules.

(viii) “Privacy Official” means that person designated by the Employer in the Policies and Procedures to implement and enforce the Policies and Procedures.

(ix) “Protected Health Information” means Individually Identifiable Health Information that is transmitted by electronic media, maintained in any medium described in the definition of electronic media at 45 C.F.R. § 160.103 or transmitted or maintained in any other form or medium; provided, however, that Protected Health Information does not include Individually Identifiable Health Information in education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. § 1232g, records described at

20 U.S.C. § 1232g(a)(4)(B)(iv), employment records held by a health plan in its role as employer, and records regarding a person who has been deceased for more than fifty (50) years.

(x) “Required by Law” means a mandate contained in law that is enforceable in a court of law and includes, but is not limited to:

(A) court orders and court-ordered warrants,

(B) subpoenas or summons issued by a court, grand jury, governmental or tribal inspector general or administrative body authorized to require the production of information,

(C) civil or an authorized investigative demand,

(D) Medicare conditions of participation with respect to health care providers participating in the program, and

(E) statutes or regulations that require the production of information.

(xi) “Summary Health Information” means information that may be Individually Identifiable Health Information, and:

(A) that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Employer had provided health benefits under the Plan, and

(B) from which the information described at 45 C.F.R. § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 C.F.R. § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

(xii) “Unsecured Protected Health Information” means Protected Health Information that is not rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of the Health and Human Services.

(b) Identity of Plan Sponsor.

(i) The Employer shall be the plan sponsor for purposes of the Privacy Rules when using or disclosing Protected Health Information in accordance with Section 7.1(c) and when otherwise acting on behalf of the Plan with respect to the Plan’s obligations under the Privacy Rules.

(ii) The Privacy Official shall act for the plan sponsor and shall be entitled to delegate its powers and responsibilities in accordance with its usual practices.

(iii) Individuals and classes of individuals identified in Section 7.1(f) shall assist the Privacy Official.

(c) Permitted Uses and Disclosure of Protected Health Information.

(i) Subject to obtaining written certification from the Employer as described in Section 7.1(e) and except as provided in Section 7.1(c)(ii), the Plan may disclose Protected Health Information to the Employer only for the purpose of performing Plan Administration Functions. Only those individuals identified in Section 7.1(f) will be permitted to access and use Protected Health Information disclosed under this paragraph and may access and use it solely for the purposes of performing Plan Administration Functions, consistent with any conditions or restrictions imposed on, or otherwise agreed to by, the Employer pursuant to this Section 7.1.

(ii) In addition, the Plan may disclose to the Employer information on whether an individual is participating in the Plan and may disclose Summary Health Information to the Employer, provided the Employer requests Summary Health Information for the purpose of:

(A) obtaining premium bids from health plans for providing health insurance coverage under or on behalf of the Plan (except that no genetic information may be disclosed for underwriting purposes, as provided in 45 C.F.R. § 164.502(a)(5)(i)), or

(B) modifying, amending or terminating the Plan.

(iii) The Plan shall not disclose Protected Health Information to the Employer unless the Notice contains the statement required by 45 C.F.R. § 164.520(b)(1)(iii)(B).

(iv) Notwithstanding any provisions of the Plan to the contrary, in no event will the Employer be permitted to use or disclose Protected Health Information in a manner that is inconsistent with 45 C.F.R. § 164.504(f).

(v) In no event shall the use or disclosure of Protected Health Information by the Plan Administrator exceed the amount reasonably determined by the Plan Administrator to be the minimum use or disclosure necessary to accomplish the intended purpose of the use, disclosure, or request. The Plan Administrator will limit such Protected Health Information, to the extent practicable, to the limited data set (as defined in 45 C.F.R. § 164.514(e)(2)) or, if needed, to the minimum necessary.

Disclosures made on a routine and recurring basis will be made pursuant to standard policies and procedures that limit the disclosure to the minimum necessary. All other disclosures will be reviewed on an individual basis to determine that the disclosure is limited to the information reasonably necessary to accomplish the purpose of the request.

(vi) The Plan may otherwise use and disclose Protected Health Information in accordance with the Privacy Rules and the Plan's Policies and Procedures.

(d) Protected Health Information Disclosure Conditions. The Plan will disclose Protected Health Information to the Employer as provided in Section 7.1(c)(i) only if the Employer furnishes the certification set forth in Section 7.1(e), and the Employer agrees that with respect to any Protected Health Information disclosed to it by the Plan, the Employer will:

(i) not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as Required by Law,

(ii) ensure that any agents to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such Protected Health Information,

(iii) not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee Welfare Program of the Employer, (except to the extent such other Welfare Program, program or arrangement is part of an organized health care arrangement, of which the Plan also is a part),

(iv) report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for, of which it becomes aware,

(v) make Protected Health Information available to an individual who requests access to his/her Health Information in accordance with 45 C.F.R. § 164.524,

(vi) make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. § 164.526,

(vii) maintain and make available information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528,

(viii) make its 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 compliance by the Plan with Subpart E of 45 C.F.R. § 164,

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

(x) ensure that the adequate separation between the Plan and the Employer, required in 45 C.F.R. § 164.504(f)(2)(iii), is established.

(e) Employer Certification. The Plan will disclose Protected Health Information to the Employer as provided in Section 7.1(c)(i) only upon the receipt of a certification from the Employer that the Plan has been amended to incorporate the provisions of

45 C.F.R. § 164.504(f)(2)(ii), and that the Employer agrees to the conditions set forth in Section 7.1(d).

(f) Adequate Separation Between the Plan and the Employer for Plan Administration Functions. The Employer will allow only the employees or classes of employees or other persons under the Employer's control who are specifically authorized pursuant to the Plan's Policies and Procedures to access and use Protected Health Information for Plan Administration Functions in accordance with Section 7.1(c). Protected Health Information disclosed to these individuals under Section 7.1(c)(i) may be accessed and used only for purposes of performing Plan Administration Functions.

(g) Disciplinary Sanctions and Mitigation of Harm. In the event that any individual specified in Section 7.1(f) does not comply with the provisions set forth in this Section 7.1, that individual will be subject to disciplinary action by the Employer (which may include termination) for such non-compliance, as set forth in the Policies and Procedures. In addition, the Plan will take all necessary action to mitigate any harm caused by an individual's failure to comply with the provision in this Section 7.1.

(h) Compliance with Health Privacy Laws. To the extent applicable, the Plan will comply with Subpart E of 45 C.F.R. § 164 and any other applicable Federal, state and local laws governing the safeguarding of health privacy matters.

(i) Interpretation of HIPAA Privacy Rules. The provisions of this Section 7.1 are meant to comply with (and not expand upon) the requirements of the HIPAA Privacy Rules and shall be interpreted accordingly. In the event that any of the provisions of this Section 7.1 are not applicable, are superseded or are no longer required under HIPAA, they shall be deemed to be deleted from the Plan and shall have no further force or effect.

(j) Security Standards for Electronic Protected Health Information. In order to safeguard any Electronic Protected Health Information created, received, maintained or transmitted to or by the Employer on behalf of the Plan, the Employer shall:

(i) 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,

(ii) ensure that the adequate separation between the Plan and the Employer required by Section 7.1(f) and 45 C.F.R. § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures,

(iii) ensure that any agent to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect that Information, and

(iv) report to the Plan any security incident of which it becomes aware.

(k) Notification of Breach of Unsecured Protected Health Information.

(l) Breach Notification. In the case of a Breach of Unsecured Protected Health Information, the Plan Administrator, following the discovery of the Breach, will notify each individual whose Unsecured Protected Health Information has been, or is reasonably believed by the Plan Administrator to have been, accessed, acquired, used or disclosed as a result of such Breach.

(i) Timing of Notification. The notice of a Breach will be provided without unreasonable delay and in no case later than sixty (60) calendar days after discovery of the Breach.

(ii) Content of Notification. The notice of a Breach will be provided in writing or in electronic form, in accordance with the requirements of 45 C.F.R. § 164.404(d), in plain language, and will include, to the extent possible:

(A) a brief description, the date, and the date of the discovery, of the Breach, if known;

(B) a description of the types of Unsecured Protected Health Information that were involved in the Breach;

(C) any steps individuals should take to protect themselves from potential harm resulting from the Breach;

(D) a brief description of the Plan's actions to investigate the Breach, to mitigate harm to individuals and to protect against any further breaches; and

(E) contact procedures for individuals to obtain additional information, including a toll-free telephone number, an e-mail address, web site or postal address.

7.2 Special Enrollment Rights. (a) In accordance with the HIPAA special enrollment rules, if an eligible Employee declines coverage in a group health plan for himself and/or his spouse and dependents because of other health insurance coverage, they may be able to enroll in the Plan's group health coverage upon loss of eligibility for the other coverage, provided that the Participant requests enrollment within 30 days of the other coverage ending.

If a Participant gains a new dependent as a result of marriage, birth, adoption, or placement for adoption, he may be able to enroll himself and his dependents, in the group health Welfare Program provided that enrollment is requested within 30 days after the marriage, birth, adoption, or placement for adoption.

(b) Children's Health Insurance Program Reauthorization Act ("CHIPRA"). A special enrollment period shall be offered to an eligible Employee and Dependents who are not enrolled in the Plan to enroll for coverage under the Plan if (i) they are covered under Medicaid or a state child health plan ("CHIP") and such coverage terminates because of a loss of eligibility, or (ii) they become eligible for assistance under Medicaid or CHIP. An eligible Employee must request coverage under the Plan no later than 60 days after the date coverage

under Medicaid or CHIP terminates or after the date the eligible Employee becomes eligible for Medicaid or CHIP.

(c) The special enrollment rules of this Section 7.2 do not apply to limited scope dental or vision benefits or certain health care flexible spending accounts (e.g., health care spending accounts that limit benefits to employee salary reduction amounts).

7.3 Qualified Medical Child Support Orders. The provisions of this Section are intended to implement ERISA Section 609(a) with respect to medical child support orders (“MCSO”) and qualified medical child support orders (“QMCSO”). This Section may not be interpreted to grant any additional rights upon any party, or to expand the jurisdiction of any court or governmental authority beyond what is required by ERISA Section 609(a). The Plan Administrator shall comply with the terms of any QMCSO it receives, and shall:

(a) Establish reasonable procedures to determine whether a medical child support order is a QMCSO as defined under Section 609 of ERISA;

(b) Promptly notify the Participant and any alternate recipient of the receipt of a medical child support order, and the group medical plan’s procedures for determining whether the medical child support order is a QMCSO; and

(c) Within a reasonable period of time after receipt of such order, determine whether such order is a QMCSO and notify the Participant and each alternate recipient of such determination.

(d) Definitions:

(i) A MCSO is a medical child support order as defined in ERISA Section 609(a)(2)(B).

(ii) A QMCSO is a qualified medical child support order as defined in ERISA Section 609(a)(2)(A).

7.4 State Medicaid Programs. Eligibility for coverage or enrollment in a state Medicaid Program shall not impact an Employee’s, Spouse’s or Dependent’s eligibility for health coverage or health benefits under the Plan.

7.5 Coverage During FMLA Leave. A Participant on an approved unpaid leave of absence that qualifies as family and medical leave under the Family and Medical Leave Act of 1993 (“FMLA”) may continue to receive group health plan coverage under this Plan during such leave along with his eligible Spouse and Dependents as if such Participant did not experience an interruption in active employment until the end of such FMLA leave period, or, if earlier, the date the Participant gives notice that he does not intend to return to work at the end of the FMLA period. The Participant must make any required contributions for group health plan coverage during such period in such time and manner as the Plan Administrator may require and in accordance with the terms of any applicable plan subject to Code Section 125 sponsored by the Employer.

7.6 Special Rules for Maternity and Infant Coverage. Any health plan available under the Plan shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The attending provider or physician, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). Notwithstanding the foregoing, the health plan and issuers may not require that a provider obtain authorization from the health plan or the issuer for prescribing the length of stay not in excess of 48 hours or 96 hours, as the case may be.

7.7 Special Rule for Women's Health. If a health benefit plan available under the Plan provides medical and surgical benefits for mastectomy procedures it shall provide coverage for reconstructive surgery following mastectomies. This expanded coverage includes reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications at all stages of mastectomy, including lymphedemas. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other benefits under the health benefit plan or coverage.

7.8 Michelle's Law (H.R. 2851). Contrary Plan provisions notwithstanding, a Dependent child who is on a "medically necessary leave of absence", but who was attending a post-secondary educational institution before the first day of the leave of absence, shall be allowed to maintain his or her eligibility under the Plan. Coverage under the Plan must be extended under the sooner of (1) one year from the state of the medically necessary leave of absence or (ii) the date coverage would otherwise terminate under the terms of the Plan. A "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution or any other change in enrollment that (i) begins while the student is suffering from a severe illness or injury, (ii) is medically necessary, and (iii) causes the loss of full-time student status under the Plan. The extended coverage shall provide the same benefits as if the child was not on a medically necessary leave of absence. Such Dependents must have a physician certify that the student has a severe illness or injury and that the leave from school is medically necessary.

7.9 Certificate of Coverage Under the Group Health Plan. Certificates of coverage are written documents provided by a group health plan to show the type of health care coverage an individual had (e.g., employee only, family, etc.) and how long the coverage lasted. The certificates are used to determine if an individual experiences a 63-day break in health coverage. The group health plan shall provide such certificates automatically when an individual's coverage terminates. However, if the individual does not receive a certificate, the individual has the right to request one. Certificates apply to Participants, Spouses and Dependents. The certificates shall provide the amount of "creditable coverage" that the individual had under a group health plan. The group health plan shall automatically provide the individual a certificate after the individual loses coverage (whether regular coverage or COBRA continuation coverage) and shall make reasonable efforts to provide on the certificate the names of any family members who were also covered and whose coverage was terminated. The group health plan shall provide automatic certificates for a person when it has reason to know that they are no longer covered. In addition, the group health plan will provide a certificate for the person upon request if the individual makes the request within two years (24 months) after the coverage terminates. For

purposes of this Section, a group health plan is a welfare plan that provides medical benefits and certain employee assistance plans that are not just referral services. It does not include limited scope dental and vision benefits or certain health care spending accounts such as a plan funded solely by participant salary reduction contributions.

The time between the loss of health coverage and the beginning of health coverage, if elected during a second election period as defined in Section 7.10(h), does not count for purposes of determining if an individual has experienced a 63-day break in coverage.

7.10 Military Leave. A Participant's right to elect continued participation in a group health plan available under this Plan for himself, his Spouse and Dependents during a leave of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act ("USERRA").

(a) Participants may elect to continue group health plan coverage under the Plan for a period of time that is the lesser of:

(i) the 24-month period beginning on the Participant's first day of military leave, or

(ii) the period beginning on the Participant's first day of military leave and ending on the date the Participant fails to return from military leave or apply for re-employment as required under USERRA.

(b) If a Participant's absence for military duty is less than 31 days, the Participant will be required to pay the regular employee's share of the cost for group health plan coverage. If the Participant's absence is for 31 or more days, the Participant will be required to pay not more than 102% of the full cost of his group health plan coverage (and his Spouse and Dependents) under the Plan.

(c) USERRA continuation group health plan coverage is considered alternative group health plan coverage for purposes of COBRA. Therefore, if a Participant elects USERRA continuation coverage, COBRA continuation group health plan coverage shall not be available.

(d) Participants returning from military leave shall be reinstated upon re-employment, and any exclusion or waiting period shall not be imposed if such exclusion or waiting period would not have been imposed had the Participant's coverage not been terminated due to military leave. This paragraph shall not apply to illnesses or injuries determined by the Secretary of Veteran's Affairs or his representative to have been incurred in, or aggravated during, the performance of military service.

(e) In no event shall benefits available under this Plan during a period of USERRA qualified military leave be less generous than those benefits available during other comparable employer approved leave periods (*e.g.*, family and medical leave).

7.11 Other Employer-Approved Leaves of Absence. Contrary Plan provisions notwithstanding, and solely if a Participant's leave of absence is not covered by Section 6.10 and

6.15, the Plan Administrator may permit a Participant taking an employer-approved leave of absence to continue receiving benefits under the Plan in accordance with the applicable Welfare Program or other applicable policy. Except with respect to active employment requirements under the Welfare Program to which this Section applies, all terms of such Welfare Program shall still apply to the Participant's, Spouse's and any Dependent's continued coverage under the Welfare Program.

7.12 COBRA.

(a) Legal Rights to Continuation Coverage Under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). The Employer shall offer a Participant and/or a Spouse or Dependent who, as a result of a Qualifying Event, becomes otherwise ineligible to participate under the Plan, the opportunity to temporarily extend coverage under the Plan.

(b) Qualifying Events.

(i) A Participant who loses group health plan coverage or for whom premium payments or contributions for coverage increase as a result of one of the following qualifying events, shall be eligible for COBRA continuation coverage.

(A) A reduction of the Participant's hours of employment;

(B) The Participant's voluntary or involuntary termination of employment for reasons other than gross misconduct; or

(C) Upon the Employer's bankruptcy petition under Title XI of the Bankruptcy Act, if the Participant is a retired employee.

(ii) A Spouse who loses group health plan coverage or for whom premium payments or contributions for coverage increase as a result of one of the following qualifying events, shall be eligible for COBRA continuation coverage.

(A) The Participant's voluntary or involuntary termination of employment for reasons other than gross misconduct, or reduction of hours of employment;

(B) The death of the Participant;

(C) The divorce or legal separation of the Participant and Spouse;

(D) Enrollment in Medicare (Part A or B) by the Participant; or

(E) The Employer's bankruptcy petition under Title XI of the Bankruptcy Act, if the Participant is retired.

(iii) A Participant's Dependent who loses group health plan coverage or for whom premium payments or contributions for coverage increase as a result of one of the following events, shall be entitled to COBRA continuation coverage.

- (A) The loss of Dependent status under the group health plan;
- (B) The Participant's voluntary or involuntary termination for reasons other than gross misconduct, or the Participant's reduction of hours of employment;
- (C) The death of the Participant;
- (D) The divorce or legal separation of the Participant and Spouse;
- (E) Enrollment in Medicare (Part A or B) by the Participant; or
- (F) The Employer's bankruptcy petition under Title XI of the Bankruptcy Act, if the Participant is retired.

(c) Qualified Beneficiary. A. Qualified Beneficiary is either a Participant, spouse, or dependent who on the day before a Qualifying Event is covered under a group health plan available under the Plan. Qualified Beneficiary includes children born, adopted or placed for adoption with the Participant during his COBRA continuation coverage period. Such child's coverage period shall be determined according to the date that the Participant's COBRA continuation coverage period began. A domestic partner or common law spouse is not a Qualified Beneficiary for COBRA purposes and therefore shall not be entitled to COBRA continuation coverage unless otherwise required under applicable law.

(d) Notices. A qualified beneficiary who wishes to receive COBRA continuation coverage as a result of divorce or legal separation must notify the Plan Administrator within 60 days after such divorce or legal separation. A qualified beneficiary who wishes to receive COBRA continuation coverage as a result of the loss of Dependent status under the group health plan available under the Plan must notify the Plan Administrator within 60 days of such loss of Dependent status.

The qualified beneficiary shall be notified of his right to elect continuation coverage and the cost to do so. Continuation coverage must be elected within 60 days after the later of the date coverage under the group health plan available under the Plan ceases or the date the qualified beneficiary is notified of the right to elect continuation coverage.

If the qualified beneficiary does not elect continuation coverage, coverage under the group health plan available under the Plan shall cease. If the qualified beneficiary chooses continuation coverage, such group health plan shall provide coverage identical to that available to similarly situated active employees, including the opportunity to choose among options available during an open enrollment period.

(e) Cost. The qualified beneficiary must pay the full cost of such coverage to the Plan for a similarly situated active employee. The Plan may charge a 2% administrative fee. The COBRA premium may increase to 150% of the total premium during a disability extension as described in paragraph (f)(iv).

(f) Maximum Continuation Period.

(i) A qualified beneficiary who loses group health plan coverage available under the Plan as a result of the death of the Participant, the Participant's eligibility for Medicare, divorce, legal separation or loss of Dependent status under such group health plan and elects COBRA continuation coverage, shall be entitled to receive up to 36 months of COBRA continuation coverage beginning on the date on which the qualifying event occurred.

(ii) A qualified beneficiary who loses group health plan coverage as a result of the Participant's termination of employment or reduction of hours and elects COBRA continuation coverage, shall be entitled to receive up to 18 months of COBRA continuation coverage beginning on the date on which the qualifying event occurred. If a second qualifying event occurs during such 18-month period, the COBRA continuation coverage period may be extended by an additional 18 months for each qualified beneficiary (other than a covered employee). The qualified beneficiary must notify the Plan Administrator within 60 days of a second qualifying event to receive the additional 18 months of continuation coverage. A second qualifying event is an event that occurs during the initial 18-month period that would have resulted in a loss of group health plan coverage for a similarly situated active employee participating in the group health plan. In no event, however, shall any qualified beneficiary's COBRA continuation coverage period exceed 36 months.

(iii) A loss of coverage will occur at the end of the month of the Qualifying Event and COBRA continuation coverage, if elected, will begin on the first day of the following month. For example, if a Participant terminates employment on March 15, the group health plan will continue coverage through March 31, and if elected by the Participant, COBRA coverage will begin on April 1 and continue for 18 months (unless earlier terminated as provided herein).

(iv) A qualified beneficiary (other than the Participant) who loses group health plan coverage as a result of the Participant's termination of employment or reduction of hours and such event occurs within 18 months following the Participant's enrollment in Medicare, shall be entitled to receive up to 36 months of COBRA continuation coverage beginning on the date the Participant enrolled in Medicare.

(v) Any qualified beneficiary who is deemed to have been disabled, as determined by the Social Security Administration at any time during the 60-day period in which he or she became eligible for COBRA continuation coverage, shall be eligible to extend the COBRA continuation coverage period to 29 months. Such extension shall apply to the qualified beneficiary's covered family members. Such qualified beneficiary must notify the Plan Administrator of the disability before the end of the 18-month continuation coverage period. In the case of a child born to or adopted by a Participant during his COBRA continuation coverage period, such 60-day period will begin from the date of birth or placement of adoption. A

qualified beneficiary receiving extended COBRA continuation coverage due to disability must inform the Plan Administrator within 30 days of receiving a final determination that he or she is no longer disabled.

(vi) A retiree or retiree's Spouse or Dependent entitled to COBRA continuation coverage as a result of the Employer's bankruptcy proceedings under Title XI of the Bankruptcy Act shall have such coverage until (A) the death of the retiree or the retiree's surviving Spouse if the retiree died before the bankruptcy filing and such Spouse was covered under the group health plan; or (B) 36 months after the death of the retiree in the case of the retiree's surviving Spouse or Dependents.

(g) Termination of COBRA Continuation Coverage. COBRA continuation coverage shall cease upon the occurrence of any of the following events:

(i) The Employer ceases to provide group health plan coverage to any of its employees;

(ii) The qualified beneficiary fails to pay the premium or required contribution within 30 days after its due date;

(iii) The qualified beneficiary becomes covered, after the date of the COBRA continuation coverage election, under another group health plan, including a governmental plan, that does not contain any exclusion or limitation with respect to any preexisting condition of such qualified beneficiary (other than an exclusion or limitation that may be disregarded under the law);

(iv) The qualified beneficiary becomes enrolled in Medicare after the date of the COBRA continuation coverage election;

(v) The qualified beneficiary has extended COBRA continuation coverage due to a disability and is subsequently determined by the Social Security Administration to be no longer disabled;

(vi) The maximum required COBRA continuation coverage period expires; or

(vii) For cause, such as fraudulent claim submission, that would result in termination of coverage for a similarly situated active employee.

7.13 Genetic Information Nondiscrimination Act of 2008. The Plan shall comply with the requirements of the Genetic Information Nondiscrimination Act of 2008 ("GINA"). The Plan shall not, except as otherwise allowed under GINA, (i) adjust premium or contribution amounts on the basis of "genetic information", (ii) request or require an individual or a "family member" of such individual to undergo a "genetic test" or (iii) request, require or purchase genetic information for "underwriting purposes" or with respect to any individual prior to enrollment under the Plan in connection with such enrollment (as those terms are defined under GINA).

7.14 Mental Health and Substance Use Parity. To the extent that any Welfare Program provides mental health and substance use disorder benefits, such Welfare Program shall comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the “Parity Act”). The Plan Administrator shall ensure that under each applicable Welfare Program, the “financial requirements” and “treatment limitations” (as those terms are defined under the Parity Act) applicable to mental health and substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits coverage, and that there are no separate cost sharing requirements or treatment limitations applicable only with respect to mental health or substance use disorder benefits.

ARTICLE VIII

AMENDMENT AND TERMINATION

8.1 Amendment. The Employer has the right to amend or modify the Plan at any time, to any extent that it may deem advisable, including the right to amend any of the Welfare Programs or to transfer any Welfare Program from the Plan into a separate, related plan. Any amendment shall be at the direction of an authorized officer of the Employer or his authorized designee.

8.2 Termination. The Employer has established the Plan with the bona fide intention and expectation that it will be continued indefinitely but the Employer is not and shall not be, under any obligation or liability whatsoever to maintain the Plan (or any Welfare Program) for any given length of time and may, in its sole and absolute discretion, discontinue or terminate the Plan, in whole or in part, at any time, including termination of any one or more of the Welfare Programs, at the direction of an authorized officer of the Employer or his authorized designee.

ARTICLE IX

MISCELLANEOUS

9.1 Exclusive Benefit. This Plan has been established for the exclusive benefit of Participants, Spouses, Dependents or Beneficiaries, and except as otherwise provided herein, all contributions under the Plan may be used only for such purpose.

9.2 Communication to Employees. The Employer will from time to time notify all Employees of the availability and terms of the Plan and the Welfare Programs hereunder.

9.3 Non-Alienation of Benefits. No benefit, right or interest of any Participant, Spouse, Dependent or Beneficiary under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law or, in the case of assignments, as permitted under the terms of a Welfare Program, and any attempt to accomplish the same shall be void. This prohibition includes any interest in, or benefit payable under the Plan from being subject to any legal or equitable process including garnishment, attachment, levy, seizure or lien. This means

that a Participant, Spouse or Dependent cannot assign to a health care provider (or anyone) the Participant's, Spouse's or Dependent's rights to receive benefits under the Plan or to bring a claim or lawsuit for benefits or for breach or violation of any other duty or obligation owed to the Participant, Spouse or Dependent under the plan. No medical provider, or any other person or entity is permitted to bring a claim against the Plan under ERISA or any other law through a purported assignment, and any attempt to assign such rights will be void and unenforceable. In no event will the Plan or the Employer be liable to any third party to whom a Participant, Spouse or Dependent may be liable for care, treatment or other services.

9.4 Limitation of Rights. Neither the establishment nor the existence of the Plan, nor any modification thereof, shall operate or be construed as to:

- (a) give any person any legal or equitable right against the Employer or Participating Employer except as expressly provided herein or required by law, or
- (b) create a contract of employment with any Employee, obligate the Employer or Participating Employer to continue the service of any Employee, or affect or modify the terms of an Employee's employment in any way.

9.5 Governing Laws and Jurisdiction and Venue. The Plan shall be construed and enforced according to the laws of the State of Rhode Island, to the extent not preempted by Federal law which shall otherwise control. Exclusive jurisdiction and venue of all disputes arising out of or relating to this Plan or any of the Welfare Programs shall be in any court of appropriate jurisdiction in the State of Rhode Island.

9.6 Severability. If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such invalid or unenforceable provision had not been included herein.

9.7 Construction. The captions contained herein are inserted only as a matter of convenience and reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and the neuter are interchangeable.

9.8 Titles. The titles of the Articles and Sections hereof are included for convenience only and shall not be construed as part of the Plan or in any respect affecting or modifying its provisions. Such words in this Plan as "herein," "hereinafter," "hereof" and "hereunder" refer to this instrument as a whole and not merely to the subdivision in which said words appear.

9.9 Expenses. Subject to the terms of the Welfare Programs, any expenses incurred in the administration of the Plan shall be paid by the Plan and/or by the Employer, according to the Employer's determination.

9.10 Deadline Extensions Related to COVID-19 Pandemic: Pursuant to EBSA Disaster Relief Notice 2021-01, certain deadlines are extended for up to one year from the date the action would otherwise be required or permitted, but in no event later than 60 days after the

end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak (the "Outbreak Period"). This extension does not apply to Plan deadlines that expired prior to March 1, 2020. This extension applies to the participant deadlines under the Plan for:

- Requesting special enrollment under HIPAA;
- Electing COBRA continuation coverage;
- Making COBRA premium payments;
- Notifying the Plan Administrator of a qualifying event (or disability determination) under COBRA;
- Filing a claim for benefits under the Plan;
- Appealing an adverse benefit determination under the Plan; and
- Commencing an external review after exhausting all internal appeals procedures.

In addition, in accordance with EBSA Disaster Relief Notice 2021-01, the deadlines for the Plan Administrator to furnish benefit statements and other notices and disclosures under ERISA are extended during the Outbreak Period, provided the Plan Administrator will provide the documents as soon as administratively practicable under the circumstances.

ARTICLE X

EFFECTIVE DATE

The effective date of this amended and restated Plan is January 1, 2021.

* * * * *

IN WITNESS WHEREOF, the Employer has caused this instrument to be duly executed in its name and on behalf this 14th day of December, 2021.

BROWN UNIVERSITY

By: _____

Russell Carey

Interim Executive Vice President for
Finance and Administration

APPENDIX B

BROWN UNIVERSITY HEALTH AND WELFARE PLAN ELIGIBILITY AND CONTRIBUTION CHART

<u>Benefit Program</u>	<u>Eligibility</u>	<u>Employee Contribution</u>
Health Insurance	The following employees who work at least 1300 hours per year: Faculty/Staff Dining Services Facilities Management Public Safety Library	Employee contributes pre-tax based on formula used for specific employee group; Buyout is available.
	The following employees who work at least 975 to 1299 hours per year: Faculty/Staff Dining Services Facilities Management Public Safety Library	Employee contributes one-half the monthly premium pre-tax; Buyout is available (i.e., half the full Buyout amount).
	The following employees who work less than 975 hours per year Faculty/Staff Dining Services Facilities Management Public Safety	Employee may enroll but is required to contribute full monthly premium on an after-tax basis; Buyout not available.
	Library employees who work between 780 and 975 hours per year	Employee may enroll but is required to contribute full monthly premium on a pre-tax basis; Buyout not available.
	Library employees who work less than 780 hours per year	Employee may enroll but is required to contribute full monthly premium on an after-tax basis; Buyout not available.

<u>Benefit Program</u>	<u>Eligibility</u>	<u>Employee Contribution</u>
Dental Insurance	The following employees who work at least 1300 hours per year: Faculty/Staff Dining Services Facilities Management Public Safety Library	Employer contributes one-half of the cost of monthly individual coverage; Employee contributes the balance for all levels of coverage on pre-tax basis.
	The following employees who work at least 975 to 1299 hours per year: Faculty/Staff Dining Services Facilities Management Public Safety Library	Employer contributes one-quarter of the cost of monthly individual coverage; Employee contributes the balance for all levels of coverage on pre-tax basis.
	The following employees who work less than 975 hours per year: Faculty/Staff Dining Services Facilities Management Public Safety	Employee may enroll but is required to contribute full monthly premium on after-tax basis.
	Library employees who work between 780 and 975 hours per year	Employee may enroll but is required to contribute full monthly premium on pre-tax basis.
	Library employees who work less than 780 hours per year	Employee may enroll but is required to contribute full monthly premium on after-tax basis.
Life Insurance	The following employees who work at least 1300 hours per year: Faculty/Staff Dining Services Facilities Management Public Safety Library hired before January 1, 1994	Employer fully pays; Employee eligible for coverage. Employee may elect to fully pay for additional voluntary life insurance, which is available for self, spouse/partner, or children.

<u>Benefit Program</u>	<u>Eligibility</u>	<u>Employee Contribution</u>
Long Term Disability Insurance	<p>The following employees who have worked at least 1300 hours for one uninterrupted year <u>and</u> continue to work at least 1300 hours per year:</p> <p style="padding-left: 40px;">Faculty/Staff Dining Services Facilities Management Public Safety Library</p> <p>It is possible to waive the initial one year waiting period if you are newly hired and were covered by the long term disability insurance plan of your former employer.</p> <p>If you were, in fact, covered within three months of the date when your initial waiting period begins and would like to have your waiting period waived, you must submit appropriate documentation of your coverage, on a timely basis, to the Brown University Benefits Office.</p>	Employer fully pays; Employee eligible for coverage.
Supplemental Long Term Disability Insurance	<p>The following employees who work at least 1300 hours per year and are enrolled in Long Term Disability Insurance Plan:</p> <p style="padding-left: 40px;">Faculty/Staff Public Safety Dining Services Facilities Management Library</p>	Employee pays full cost of coverage.
Premium Conversion Plan (“PCP”)	<p>The following employees who work at least 975 hours per year:</p> <p style="padding-left: 40px;">Faculty/Staff Dining Services Facilities Management Public Safety</p>	Employee eligible to make pre-tax contributions (via PCP) to pay for Health and Dental Insurance coverages.

<u>Benefit Program</u>	<u>Eligibility</u>	<u>Employee Contribution</u>
	Library Employees working at least 780 hours per year	Employee eligible to make pre-tax contributions (via PCP) to pay for Health and Dental Insurance coverages.
Medical Reimbursement Plan (“MRP”) & Dependent Care Assistance Plan (“DCAP”)	The following employees who work at least 975 hours per year: Faculty/Staff Public Safety	Employee eligible to make pre-tax contributions to MRP and DCAP plans.
	The following employees who work at least 1300 hours per year: Facilities Management Dining Services	Employee eligible to make pre-tax contributions to MRP and DCAP plans.
	Library employees who work at least 780 hours per year	Employee eligible to make pre-tax contributions to MRP and DCAP plans.
Health Promotion Program	The following employees who are on Brown University regular payroll: Faculty/Staff Dining Services Facilities Management Public Safety Library	Employee eligible to participate at no cost.
Long Term Care Insurance	The following employees who work at least 975 hours per year: Faculty/Staff Public Safety Dining Services Facilities Management Library	Employee pays full cost of coverage.
Business Travel Accident Plan (“BTA”)	Faculty and Staff Employees who are traveling outside University-owned property in the City of Providence on assignment by or with authorization of Brown University, with travel costs being reimbursed by Brown University	Employee eligible to participate at no cost.

<u>Benefit Program</u>	<u>Eligibility</u>	<u>Employee Contribution</u>
Tuition Aid Program (“TAP”)	Tenured Faculty Employees working at least 1300 hours per year	Employee eligible to participate at no cost.
	Non-Tenured Faculty and Staff Employees working at least 1300 hours per year and have been continuously employed with Brown University for the equivalent of four years of full-time employment at the time of application	Employee eligible to participate at no cost.
Tuition Aid Program (“TAP”)	“Uncapped Faculty” Employees	Employee eligible to participate at no cost.
Employee Education Program	Staff Employees who are scheduled to work at least 1300 hours per year, are in good standing, and have completed six months of employment	Employee eligible to participate at no cost.
Faculty/Staff Assistance Program (“FSAP”)	Faculty and Staff Employees working at least 975 hours per year	Employee eligible to participate at no cost.

APPENDIX C

BROWN UNIVERSITY HEALTH AND WELFARE PLAN

PARTICIPATING EMPLOYERS

In addition to Brown University, the following Participating Employers have adopted the Plan pursuant to Section 10.1:

At this time there are no Participating Employers.

AMENDMENT
TO THE
BROWN UNIVERSITY MEDICAL REIMBURSEMENT PLAN

This Amendment to the Brown University Medical Reimbursement Plan (the “Plan”) is made and entered into by Brown University (the “Employer”).

WHEREAS, the Employer has previously established the Plan, most recently amended and restated effective January 1, 2011, for the benefit of those employees who qualify thereunder and for their beneficiaries;

WHEREAS, the Employer desires to amend the Plan as a result of regulatory guidance providing for certain extended deadlines related to the COVID-19 pandemic;

WHEREAS, the Coronavirus Aid, Relief, and Economic Security Act (“CARES Act”) and the corresponding changes to the Internal Revenue Code permit a health flexible spending account to reimburse expenses incurred for certain over-the-counter medical care products obtained without a prescription and/or menstrual care products as of January 1, 2020;

WHEREAS, the Employer desires to amend the Plan to provide that expenses incurred for certain over-the-counter medical care products obtained without a prescription and/or menstrual care products may be reimbursed as qualifying medical care expenses under the Plan as of January 1, 2020 in accordance with Plan operations during the 2020 Plan Year;

WHEREAS, the Consolidated Appropriations Act of 2021 (“CAA”) provides for limited relief from the “use-it-or-lose-it” rule applicable to health care and dependent care flexible spending accounts (“FSAs”);

WHEREAS, the Employer desires to amend the Plan in accordance with the permitted relief under the CAA to allow participants to carry over any remaining balance in their FSAs from the 2020 Plan Year to the 2021 Plan Year, and from the 2021 Plan Year to the 2022 Plan Year;

WHEREAS, Section 7.1 of the Plan allows the Employer to amend the Plan at any time.

NOW THEREFORE, the Plan is hereby amended as follows, effective as of the dates provided below:

- 1. The Plan is amended to include the following special compliance provision related to the COVID-19 pandemic:**

Deadline Extensions Related to COVID-19 Pandemic: Pursuant to EBSA Disaster Relief Notice 2021-01, certain deadlines are extended for up to one year from the date the action would otherwise be required or permitted, but in no event later than 60 days after the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak (the “Outbreak Period”). This extension does not apply to Plan deadlines that

expired prior to March 1, 2020. This extension applies to the participant deadlines under the Plan for:

- Requesting special enrollment under HIPAA;
- Electing COBRA continuation coverage;
- Making COBRA premium payments;
- Notifying the Plan Administrator of a qualifying event (or disability determination) under COBRA;
- Filing a claim for benefits under the Plan;
- Appealing an adverse benefit determination under the Plan; and
- Commencing an external review after exhausting all internal appeals procedures.

In addition, in accordance with EBSA Disaster Relief Notice 2021-01, the deadlines for the Plan Administrator to furnish benefit statements and other notices and disclosures under ERISA are extended during the Outbreak Period, provided the Plan Administrator will provide the documents as soon as administratively practicable under the circumstances.

2. Effective as of January 1, 2020, the term “Medical Expenses” in Section 2.12 is amended to read as follows:

“2.12 “Medical Expenses” means all expenses incurred by a Participant, his Spouse and Dependents during the Plan Year (and during the period that ends on the fifteenth day of the third month immediately following the end of the Plan Year, or with respect to the 2020 and 2021 plan years, such longer period as provided in Section 6.1(a) hereof) for medical care, within the meaning of Section 213 of the Code, which are not reimbursable by other means such as insurance or another Code Section 125 plan. Medical Expenses include expenses for the care, diagnosis, prevention or treatment of a disease (physical or mental), including nursing services, nursing homes, hospitalization, psychiatric care, physicians’, orthodontists’ and dentists’ care, prescription drugs, insulin, menstrual care products (as defined in Code Section 223(d)(2)(D)), over-the-counter” medications to the extent such medications qualify as “medical care” as defined in Code Section 213(d), and other medical and dental expenses covered under a medical or health care plan but unpaid due to a deductible, coinsurance or maximum coverage provision or not covered under such plan; provided, however, such expenses shall not include any medical care insurance premiums providing for medical care coverage other than such coverage as is provided for under the ordinary operation of the Plan. Medical Expenses must be incurred while the Eligible Employee is a Participant and such Medical Expenses shall be limited in accordance with Section 4.8.”

3. Section 4.6 of the Plan is hereby amended to add the following paragraph to the end thereof to read as follows:

Notwithstanding the foregoing, for the plan year beginning January 1, 2021 and ending December 31, 2021, an Eligible Employee may modify or revoke a Participation Agreement, not more than two (2) times, for any reason without having a change in status event set forth in subsections (a) through (i) above and without regard to whether the modification or revocation of the Participation Agreement is made on account of and is

consistent with a change in status event; provided, however, that an Eligible Employee may not modify or terminate a Participation Election if the total amount of reimbursements received by such Eligible Employee under the Plan prior to implementation of the election to modify or revoke exceeds the total amount of Medical Expense Contributions to the Plan until (and unless) the amount of Medical Reimbursement Contributions to the Plan equal or exceeds the year-to-date reimbursements under such account. This provision shall expire on December 31, 2021 and shall not continue in any succeeding plan years.

4. Section 5.3 of the Plan is hereby amended to add the following paragraph to the end thereof to read as follows:

“Notwithstanding the foregoing, carryover will be permitted for the 2020 and 2021 Plan Years in accordance with the Consolidated Appropriations Act of 2021. For the 2020 Plan Year, any balance remaining in the Participant’s Medical Reimbursement Account after all reimbursements hereunder will be carried over to the 2021 Plan Year and remain available to reimburse the Participant for qualifying medical care expenses incurred during the 2021 Plan Year. For the 2021 Plan Year, any balance remaining in the Participant’s Medical Reimbursement after all reimbursements hereunder will be carried over to the 2022 Plan Year and remain available to reimburse the Participant for qualifying medical care expenses incurred during the 2022 Plan Year. Amounts remaining after the expiration of the 2022 Plan Year (and any Plan Years thereafter) after all reimbursements hereunder will not be carried over to a subsequent Plan Year, and will not be available to the Participant in any other form or manner, but will remain the property of the Employer, and the Participant will forfeit all rights with respect to such balance.”

5. The second paragraph of Section 6.1(a) is amended in its entirety to read as follows:

The Plan Administrator shall only pay Medical Reimbursement Benefits with respect to Medical Expenses incurred during the Plan Year (or the period ending on the 15th day of the third month following the end of the Plan Year if the Participant has unused funds in his Medical Reimbursement Account on the last day of the Plan Year to which the Medical Reimbursement Contributions relate). Claims attributable to the current Plan Year must be submitted on or before the April 15th following the close of the Plan Year.

Notwithstanding the foregoing, for the 2020 and 2021 Plan Years in accordance with the Consolidated Appropriations Act of 2021, the grace period shall be extended. For the 2020 Plan Year, the Plan Administrator shall pay Medical Reimbursement Benefits with respect to Medical Expenses incurred through the end of 2021 if the Participant has unused funds in his Medical Reimbursement Account on the last day of the 2020 Plan Year to which the Medical Reimbursement Contributions relate. Claims attributable to this extended grace period must be submitted on or before the January 31, 2021. For the 2021 Plan Year, the Plan Administrator shall pay Medical Reimbursement Benefits with respect to Medical Expenses incurred through the end of 2022 if the Participant has unused funds in his Medical Reimbursement Account on the last day of the 2021 Plan Year to which the Medical Reimbursement Contributions relate. Claims attributable to this extended grace period must be submitted on or before the January 31, 2022.

IN WITNESS WHEREOF, the Employer has caused this Amendment to be executed as of the date below, effective as described herein.

BROWN UNIVERSITY

By: _____


Russell Carey
Interim Executive Vice President for
Finance and Administration

Date: _____

12/14/21

AMENDMENT
TO THE
BROWN UNIVERSITY DEPENDENT CARE ASSISTANCE PLAN

This Amendment to the Brown University Dependent Care Assistance Plan (the “Plan”) is made and entered into by Brown University (the “Employer”).

WHEREAS, the Employer has previously established the Plan, most recently amended and restated effective January 1, 2011, for the benefit of those employees who qualify thereunder and for their beneficiaries;

WHEREAS, the Employer desires to amend the Plan as a result of regulatory guidance providing for certain extended deadlines related to the COVID-19 pandemic;

WHEREAS, the Consolidated Appropriations Act of 2021 (“CAA”) provides for limited relief from the “use-it-or-lose-it” rule applicable to dependent care flexible spending accounts (“FSAs”);

WHEREAS, the Employer desires to amend the Plan in accordance with the permitted relief under the CAA to allow participants to carry over any remaining balance in their FSAs from the 2020 Plan Year to the 2021 Plan Year, and from the 2021 Plan Year to the 2022 Plan Year;

WHEREAS, Section 6.1 of the Plan allows the Employer to amend the Plan at any time.

NOW THEREFORE, the Plan is hereby amended as follows, effective as of the dates provided below:

1. The Plan is amended to include the following special compliance provision related to the COVID-19 pandemic:

Deadline Extensions Related to COVID-19 Pandemic: Pursuant to EBSA Disaster Relief Notice 2021-01, certain deadlines are extended for up to one year from the date the action would otherwise be required or permitted, but in no event later than 60 days after the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak (the “Outbreak Period”). This extension does not apply to Plan deadlines that expired prior to March 1, 2020. This extension applies to the participant deadlines under the Plan for:

- Requesting special enrollment under HIPAA;
- Electing COBRA continuation coverage;
- Making COBRA premium payments;
- Notifying the Plan Administrator of a qualifying event (or disability determination) under COBRA;
- Filing a claim for benefits under the Plan;
- Appealing an adverse benefit determination under the Plan; and
- Commencing an external review after exhausting all internal appeals procedures.

In addition, in accordance with EBSA Disaster Relief Notice 2021-01, the deadlines for the Plan Administrator to furnish benefit statements and other notices and disclosures under ERISA are extended during the Outbreak Period, provided the Plan Administrator will provide the documents as soon as administratively practicable under the circumstances.

2. Section 2.3(a) of the Plan is hereby amended in its entirety to read as follows:

“(a) Qualifying child as defined under Section 152 of the Code, who is under the age of 13; provided, however, for the plan year beginning January 1, 2020, a qualifying child shall include a child who attains age 13 during such plan year;”

3. Section 3.9 of the Plan is hereby amended to add the following paragraph to the end thereof to read as follows:

Notwithstanding the foregoing, for the plan year beginning January 1, 2021 and ending December 31, 2021, an Eligible Employee may modify or revoke a Participation Agreement, not more than two (2) times, for any reason without having a change in status event set forth in subsections (a) through (i) above and without regard to whether the modification or revocation of the Participation Agreement is made on account of and is consistent with a change in status event. This provision shall expire on December 31, 2021 and shall not continue in any succeeding plan years.

4. Section 3.11 of the Plan is hereby amended to add the following sentence to the end thereof to read as follows:


Notwithstanding the foregoing, for the plan year beginning January 1, 2021 and ending December 31, 2021, the \$5,000 and \$2,500 amounts referenced in subsection (iii) above, shall increase to \$10,500 and \$5,250 respectively.

5. Section 4.5 of the Plan is hereby amended to add the following paragraph to the end thereof to read as follows:

“Notwithstanding the foregoing, carryover will be permitted for the 2020 and 2021 Plan Years in accordance with the Consolidated Appropriations Act of 2021. For the 2020 Plan Year, any balance remaining in the Participant’s Dependent Care Account after all reimbursements hereunder will be carried over to the 2021 Plan Year and remain available to reimburse the Participant for qualifying dependent care expenses incurred during the 2021 Plan Year. For the 2021 Plan Year, any balance remaining in the Participant’s Dependent Care Account after all reimbursements hereunder will be carried over to the 2022 Plan Year and remain available to reimburse the Participant for qualifying dependent care expenses incurred during the 2022 Plan Year. Amounts remaining after the expiration of the 2022 Plan Year (and any Plan Years thereafter) after all reimbursements hereunder will not be carried over to a subsequent Plan Year, and will not be available to the Participant in any other form or manner, but will remain the property of the Employer, and the Participant will forfeit all rights with respect to such balance.”

IN WITNESS WHEREOF, the Employer has caused this Amendment to be executed as of the date below, effective as described herein.

BROWN UNIVERSITY

By: 

Russell Carey
Interim Executive Vice President for
Finance and Administration

Date: 12/14/21