



UNIVERSITY OF DETROIT MERCY

EMPLOYEE BENEFITS PLAN

and

SUMMARY PLAN DESCRIPTION

Amended and Restated Effective July 1, 2022

Plan Sponsor:

University of Detroit Mercy
ATTN.: Benefits Manager, Human Resources Department
4001 McNichols Rd.
Detroit, MI 48221
Telephone: (313) 993-1036

Dear Employees:

Your Employer is pleased to provide eligible Employees a comprehensive package of employee health benefits. To assist you in better understanding the terms of these benefit programs, we have prepared this University of Detroit Mercy Employee Benefits Plan and Summary Plan Description (“Plan”).

The Plan consists of two parts. First is the basic Plan document, which describes the general terms and conditions of the Plan. Second are the benefit booklets provided by the insurer or claims administrator, each of which describes a specific type of benefit provided through the Plan (e.g. benefit summary booklets provided by Aetna). All of these documents describe the benefits in effect as of July 1, 2022, except as noted otherwise. These documents, taken together, are intended to act as both the official Plan document and to provide a summary of the benefits available to you under the Plan.

We have worked hard to design a benefit package that is both responsive to your needs and affordable to you and the Employer. Except as otherwise prohibited by law, we reserve the right to change or terminate the Plan (and the benefits it provides) at any time with respect to any person covered by the Plan, including active Employees, former Employees, retirees, spouses and dependents in our sole discretion. If the Plan (or any portion of it) ends, only eligible claims incurred before the date of termination will be paid.

Efforts have been made to ensure that these documents accurately reflect the terms and conditions that apply to the benefits provided under the Plan, however, occasionally mistakes happen. In the event of a mistake in these documents, the Plan Sponsor intends to correct the mistake rather than to operate the Plan in an improper manner. Please be aware that you should not rely on any inaccurate or improper statement that is inadvertently contained in these documents. Additionally, no person has the authority to change the terms of the Plan by simply giving you a verbal opinion regarding the Plan’s terms. This means you cannot rely on any oral statement that deviates from the express terms of the Plan.

The Plan is not an employment contract. Nothing in these materials gives any Employee the right to continued employment or limits the right of the Employer to discharge an Employee at any time, with or without cause or prior notice.

The Plan Administrator is available to answer any questions you may have so that you can take advantage of the benefits the Employer provides to you. We know you will appreciate the security that the Plan provides and hope that through good health and good fortune you will seldom need these benefits.

Sincerely,

University of Detroit Mercy

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Attachments to this document include the Certificates of Insurance, Insurance Policies, and Benefit Booklets, as applicable, for the following benefits:

- Medical and Prescription Drug Base Plan
- Medical and Prescription Drug High Deductible Health Plan
- Medical and Prescription Drug -- Medicare Advantage Plan PPO
- Vision
- Dental PPO
- Employee Basic Term Life Insurance; Accidental Death and Dismemberment
- Voluntary Term Life Insurance
- Long-Term Disability
- Short-Term Disability
- Flexible Benefits
- On-Site Dental Clinic
- Employee Assistance Program
- Wellness Program

The University of Detroit Mercy (“UDM”) is the Plan Sponsor of the University of Detroit Mercy Employee Benefits Plan (the “Plan”), previously separately known as the University of Detroit Mercy Medical Plan and the University of Detroit Mercy Flexible Spending Plan. UDM hereby consolidates, amends, and restates the Plan and Summary Plan Description, effective as of July 1, 2022.

**ARTICLE I
PLAN COVERAGES**

The Plan consists of the general terms and conditions contained in this document and the following benefits coverage, which are described in the Benefit Booklets provided by the insurer or claims administrator (“Contract Administrator”) and are considered a part of this Plan, included as appendices.

<u>Name of Benefit</u>
Medical and Prescription Drug Base Plan*
Medical and Prescription Drug High Deductible Health Plan (“HDHP”) and Health Savings Account (“HSA”)**
Medical and Prescription Drug -- Medicare Advantage Plan PPO+
Vision+
Dental PPO+
Employee Basic Term Life Insurance; Accidental Death and Dismemberment+
Voluntary Term Life Insurance+
Long-Term Disability+
Short-Term Disability+~
Flexible Benefits (Pre-Tax Premium; Health Care and Dependent Care Reimbursement Accounts; Opt-Out Benefits)*~
On-Site Dental Clinic*
Employee Assistance Program+
Wellness Program (Online Health Assessment, Health Coaching, and Health Educational Tools; Nurse-Staffed Information Line; Medical Management Programs; Patient Safety Program; Discounts on Products and Services)~+

Legend:

~The portions of this document and the separate booklets referencing the Employee Retirement Income Security Act of 1974 (“ERISA”) do not apply to the Short-Term Disability Benefits, to Flexible Benefits (except the Health Care Reimbursement Flexible Spending Account), or to the Wellness Program benefits (except the Online Health Assessment and the Nurse-Staffed Information Line).

*These benefits are provided on a self-funded basis with claims determinations made by the indicated claims administrator.

+These benefits are provided through insurance purchased from the named insurance company. For these benefits, only the insurance company or carrier can determine your eligibility for and amount of benefits. Therefore, the only benefits provided by the Plan for any of these insured benefits are the benefits **actually approved and paid** by the insurance company or carrier. See the applicable Certificate of Insurance and Benefit Booklets for the terms of coverage.

≠Health Savings Accounts are not benefits provided under this Plan, are not sponsored by UDM, and are not subject to ERISA. HSA contributions are made through the cafeteria portion of this plan, but the HSAs themselves are described herein solely for your convenience.

A listing of in-network service providers for Medical and Prescription Drug benefits is available from the relevant service providers, free of charge.

Many Plan benefits are provided through insurance purchased from the named insurance company. For these benefits, only the insurance company or carrier can determine your eligibility for and amount of benefits. Therefore, the only benefits provided by the Plan for any of these insured benefits are the benefits actually approved and paid by the insurance company or carrier. In contrast, Short-Term Disability, and Flexible Benefits are provided on a self-funded basis with claims determinations made by the indicated Contract Administrator.

The substantive benefits provided by each program and certain eligibility provisions and other terms and conditions are described in the individual Benefit Booklets. This basic Plan document and those booklets are intended to be interpreted consistently. In the event of conflict, the Benefit Booklets will govern over the terms of this basic Plan document, unless otherwise indicated in this document.

ARTICLE II DEFINITIONS

The separate Benefit Booklets (including insurance certificates) have definitions of important terms. In the event of conflict, the definitions in the benefit booklets will govern over the definitions of this basic Plan document, unless otherwise indicated below.

Active Employee. An Employee who is regularly works not less than 30 hours per week in the regular business of, and is compensated for services by, the Employer. Neither a Retiree nor a terminated or former employee shall be considered an Active Employee. For medical and prescription drug benefits under the Plan, you are also considered to be Active if you are absent from work due to a health status-related factor under the Health Insurance Portability and Accountability Act (“HIPAA”). For purposes of determining whether you are Active, a health status-related factor means health information, including: health status; medical conditions (including both physical and mental illnesses); claims experience; receipt of health care; medical

history; genetic information; evidence of insurability (including conditions arising out of acts of domestic violence); or disability.

Benefit. The term "Benefit" includes reimbursements or payments by this Plan or any other source, including federal or state governments or the plan of another employer, of a medical expense incurred by a Participant. It includes a benefit provided to any Employee, Retiree, or Dependent under the terms of the coverage described in the Benefit Booklets.

Benefit Year. A 12-month period beginning on January 1 and ending on the following December 31, generally used for annual claim limit purposes under the Flexible Benefit portion of the Plan.

Child. Any of the following individuals:

- A child by birth or legal adoption of an Employee, Retiree, Spouse, or Legally Domiciled Adult/Domestic Partner;
- A child placed for adoption with an Employee, Retiree, Spouse, or Legally Domiciled Adult/Domestic Partner, irrespective of whether the adoption has become final;
- A child over whom an Employee, Retiree, Spouse, or Legally Domiciled Adult/Domestic Partner has legal guardianship;
- A person who is covered by a Qualified Medical Child Support Order pursuant to Article VII.

A "child placed with an Employee, Retiree, Spouse, or Legally Domiciled Adult/Domestic Partner for adoption" means the Employee, Retiree, Spouse, or Legally Domiciled Adult/Domestic Partner has assumed and retains a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement terminates upon the termination of such legal obligation.

Code. The Internal Revenue Code of 1986, as amended.

Co-Insurance. The percentage of expenses for eligible services that the Participant must pay as his share, in excess of any Deductible required by the Plan for such services.

Co-Payment. The fixed dollar amount of expenses for eligible services that the Participant must pay as his share, in excess of any Deductible required by the Plan for such services.

Deductible. The dollar amount of expenses for eligible services that the Participant must pay before the Plan begins its payments.

Dependent. Subject to any limitations imposed under any Benefit Booklet, Dependents of eligible Employees and eligible Retirees include: a Spouse, Legally Domiciled Adult/Domestic Partner, a Dependent Child, and a Disabled Dependent.

Dependent Child. For purposes of Medical and Prescription Drug coverage:

- a Child through the end of the calendar year in which they attain age 26.

For purposes of the Dental On-Site Clinic:

- a Child until the end of the month in which they turn age 19; or
- a Child under the age of 25 if the Child is a full-time student.

Disabled Dependent. A Child of any age, who ceases to be eligible as a Dependent Child and who is incapable of self-sustaining employment due to mental disability or physical handicap, if the Child:

- became totally and permanently disabled prior to the end of the calendar year which he attained age 26;
- is unmarried;
- is primarily dependent on the Employee or Retiree for financial support and care;
- has been certified disabled by a qualified Physician upon the initial finding of disability status, and thereafter, at least annually; and
- qualifies as a “qualifying child” under Code Section 152(a)(1), or as a “qualifying relative” under Code Section 152(a)(2), both determined without regard to subsections 152(b)(1), (b)(2) and (d)(1)(B) of the Code.

Eligible Medical Expenses. The expenses defined in the applicable Benefit Booklets.

Employee. An individual classified by the Employer as a common law employee (such as by reporting wage payments on Form W-2), and excluding all other individuals, regardless of any later reclassification of their employment status. A Jesuit of UDM is not an Employee.

Full-Time Employee. An Employee who averages at least 30 Hours of Service per week for the Employer. The Employer has adopted a Look-Back Measurement Method for determining Full-Time Employee status for purposes of group medical and prescription drug coverage. Accordingly for medical and prescription drug coverage under the Plan only, the following additional provisions apply.

For a New Employee, the determination of Full-Time Employee status is made by the Employer based on the Employer’s reasonable expectations at the time of hire. For a New Employee who is classified by the Employer as a Part-Time Employee, Seasonal Employee or a Variable-Hour Employee, the Employer will determine if the Employee meets the definition of a Full-Time Employee during the Initial Administrative Period, based on Hours of Service during the Initial Measurement Period. For an On-Going Employee, this is determined annually during the Standard Administrative Period, based on Hours of Service performed during the Standard Measurement Period.

An On-Going Employee who is determined to be a Full-Time Employee during a Standard Measurement Period will be considered a Full-Time Employee for each calendar month during the Standard Stability Period associated with that Standard Measurement Period. An On-Going Employee who is determined not to be a Full-Time Employee during a Standard Measurement Period will not be considered a Full-Time Employee for any calendar month during the Standard Stability Period associated with that Standard Measurement Period.

Employer. UDM and any Related Company which, with the consent of the Plan Administrator, duly adopts this Plan in writing, and any successor corporation of UDM which duly adopts this

Plan in writing. Anything to the contrary herein notwithstanding, however, whenever any action is to be taken by the Employer pursuant to this Plan, it shall be taken by UDM on behalf of all participating Employers.

Health Plan. Except as indicated otherwise expressly or by context, Health Plan means the Medical, Prescription Drug, Dental, Vision, and Health Flexible Spending Account portions of the Plan.

Hour of Service. Each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer, and each hour for which an Employee is paid, or entitled to payment, by the Employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. The term Hour of Service does not include services to the extent the compensation for those services constitutes income from sources outside of the United States. An Hour of Service for one organization is treated as an Hour of Service for all other organizations that are related entities for all periods during which those organizations are related entities. Hours of Service for all Employees are credited using actual Hours of Service from records of hours worked and hours for which the Employee is paid or entitled to payment, where these exist. Where no records are maintained of actual hours, the Employee will be credited with 40 hours for each week in which the Employee performed any work for the Employer. For purposes of determining an Employee's average Hours of Service during an Initial Measurement Period or a Standard Measurement Period, the average Hours of Service for that period are determined by computing the average after excluding any periods of Special Unpaid Leave during that period and by using that average as the average for the entire period.

Illness. Sickness or disease, including mental infirmity, which requires treatment by a Physician. For purposes of determining benefits payable, "illness" includes pregnancy, childbirth, miscarriage, and complications of pregnancy.

Initial Measurement Period. An 11-consecutive month period commencing on the Employee's start date, during which the Employer will measure the Employee's Hours of Service for purposes of classifying them as a Full-Time Employee or not a Full-Time Employee during the subsequent Initial Stability Period.

Initial Administrative Period. For a new Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee, the 60 day period following the end of the Employee's Initial Measurement Period and prior to the beginning of the Employees Initial Stability Period, during which the Employer determines whether the Employee will be classified as Part-Time or Full-Time for the subsequent Initial Stability Period, based on Hours of Service during the Initial Measurement Period.

Initial Stability Period. For a New Employee that is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee, the 12-month period beginning on the first day following the Initial Administrative Period during which the Employee's classification as Full-Time or Part-Time will be applied regardless of the Employee's actual Hours of Service.

Injury. All injuries received by an individual in any one accident which require treatment by a Physician.

Legally Domiciled Adult or Domestic Partner. An individual over age 18 of any gender who has for at least 6 months lived in the same principal residence as the Employee/Retiree and

remains a member of the Employee's/Retiree's household throughout the coverage period; and who:

- has a close personal relationship with the Employee/Retiree (not a casual roommate or tenant);
- shares basic living expenses and is financially interdependent with the Employee/Retiree;
- is neither legally married to or the domestic partner of anyone else, nor legally related to the Employee/Retiree by blood in any way that would prohibit marriage; and
- is neither receiving benefits from an employer nor eligible for any group coverage, and is neither receiving benefits from Medicare nor eligible for Medicare.
- is the Employee's/Retiree's blood relative who meets the definition of his or her tax dependent as defined by Section 152 of the Internal Revenue Service (IRS) during the coverage period and is neither receiving benefits from an employer nor eligible for any group coverage, and is neither receiving benefits from Medicare nor eligible for Medicare.

The Plan requires a completed Legally Domiciled Adult Certification.

Limitation Year. The calendar year, used for purposes of applying various benefit provisions such as annual deductibles, Out-of-Pocket Limits, and coverage limits.

Look-Back Measurement Method. For purposes of medical and prescription drug benefits under the Plan only, the following provisions apply.

If a New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee is determined to be a Full-Time Employee during the Employee's Initial Measurement Period based on the Hours of Service credited during the Initial Measurement Period, the Employee will be considered a Full-Time Employee, and therefore an eligible Employee and may participate in medical and prescription drug coverage under the Plan, for each calendar month during the Employees Initial Stability Period.

If a New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee is determined not to be a Full-Time Employee during the Employee's Initial Measurement Period based on the Hours of Service credited during the Initial Measurement Period, the Employee will not be considered a Full-Time Employee during the Employee's Initial Stability Period, except to the extent provided under the provisions regarding On-Going Employees.

Notwithstanding the foregoing, if a New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee experiences a change in employment status before the end of the Employee's Initial Measurement Period such that, if the Employee had begun employment in that new status the Employee would have reasonably been expected to be a Full-Time Employee (and not a Seasonal Employee or Variable-Hour Employee), the Employee will be considered a Full-Time Employee beginning on the first day of the calendar month after the change in the Employee's employment status or, if earlier, at the beginning of the Employees Initial Stability Period (if the Employee is determined to be a Full-Time Employee during the Employee's Initial Measurement Period.)

Once a New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour

Employee has been employed for an entire Standard Measurement Period, the Employee becomes an On-Going Employee, and the Employee's status as a Full-Time Employee is governed by the provisions regarding On-Going Employees, subject to the following:

(a) Full-Time During the Initial Measurement Period but Not the First Standard Measurement Period. If the Employee is determined not to be a Full-Time Employee for the Standard Measurement Period that overlaps or immediately follows the Employee's Initial Measurement Period, the Employee will continue to be considered a Full-Time Employee for each calendar month during the Initial Stability Period, if the Employee was determined to be a Full-Time Employee during the Employee's Initial Measurement Period.

(b) Full-Time During the First Standard Measurement Period but Not During the Initial Measurement Period. If the Employee is determined to be a Full-Time Employee for the Standard Measurement Period that overlaps or immediately follows the Employee's Initial Measurement Period, the Employee will be considered a Full-Time Employee for each calendar month during the entire Standard Stability Period associated with the Employees first Standard Measurement Period, even though that Standard Stability Period may overlap an Initial Stability Period associated with an Initial Measurement Period during which the Employee was determined not to be a Full-Time Employee.

(c) Full-Time During Both the Initial Measurement Period and the First Standard Measurement Period. If the Employee is considered a Full-Time Employee during both the Employees Initial Stability Period and the Employee's first Standard Stability Period, the Employee will be considered a Full-Time Employee during any period between the end of the Initial Stability Period and the beginning of the Employee's first Standard Stability Period.

Marriage. A legal union that was valid in the jurisdiction in which the marriage was formed at the time the marriage was formed, as evidenced by the issuance of a marriage certificate.

Medically Necessary (Or Medical Necessity). Services or supplies received from a qualified Provider are Medically Necessary if they are required to identify or treat an illness or injury. These services or supplies must be directed and supervised by a Physician, consistent with the symptom or diagnosis and medical practice, and be the most appropriate supply or level of service with regard to a Participant's safety. Service or supplies that are solely for the convenience of a Participant or a Provider are not considered Medically Necessary. When specifically applied to an inpatient, Medically Necessary also means that the Participant's condition could not be treated safely on an outpatient basis.

Medicare. The program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended. Part A means Medicare's Hospital Plan, Part B means the Voluntary Hospital Supplemental Medical Plan of Medicare and Part D means the Prescription Drug coverage under Medicare.

New Employee. An Employee who has been employed for less than one complete Standard Measurement Period. For purposes of determining whether the employee is a New Employee or an On-Going Employee, an Employee who terminates service and is rehired or who returns to work after an unpaid leave of absence will be a New Employee upon their reemployment if the period for which no Hours of Service are credited is 13 consecutive weeks or longer. If the period for which no Hours of Service are credited is less than 13 consecutive weeks, upon their reemployment the Employee cannot be treated as a New Employee if the Employee previously was an On-Going Employee.

On-Going Employee. An Employee who has completed at least one Standard Measurement Period with the Employer.

Out-of-Pocket Limit. The maximum amount of expenses for eligible services that a Participant may pay each Limitation Year as shown in the applicable Benefit Booklet. The Out-of-Pocket Limit includes the Participant's Deductible amount and the Co-Insurance amount, but shall not include any Co-Payments, prescription drug Co-Payments, Co-Payments for mental health and substance abuse treatment, Balance Billing amounts or any charges in excess of the Usual, Reasonable and Customary Charges, Fees and Expenses or any charges over the Plan's calendar year or lifetime limits.

Participant. A properly enrolled eligible Employee, Dependent or Retiree participating in the Plan, as provided in Article III.

Part-Time Employee. For purposes of group medical and prescription drug benefits only, Part-Time Employee status is determined as follows. A Part-Time Employee is an Employee who the Employer reasonably expects to be employed on average less than 30 Hours of Service per week. For a newly hired Employee, this is based on the facts and circumstances at the Employee's start date. For a New Employee who is classified by the Employer at the start date as a Part-Time Employee, Seasonal Employee or a Variable-Hour Employee, the Employer will determine if the Employee meets the definition of a Part-Time Employee again during the Initial Administrative Period, based on Hours of Service during the Initial Measurement Period. For an On-Going Employee, Part-Time Employee status is determined annually during the Standard Administrative Period, based on Hours of Service performed during the Standard Measurement Period.

Physician. Any legally qualified and appropriately licensed medical doctor, osteopath, dentist, chiropractor, podiatrist, or ophthalmologist, any of whom provide covered services or supplies lawfully rendered within the scope of their respective licenses. In addition, such term includes a licensed nurse midwife for performing an obstetrical procedure within the scope of the license.

Plan Year. A 12-month period beginning on July 1 and ending on the following June 30, generally used for accounting and reporting purposes.

Provider. A hospital, Physician, or other provider, duly licensed and performing within the scope of the appropriate license.

Related Company. Any entity sufficiently related to the Employer to be within its controlled group of companies under Code Section 414, or within an "affiliated service group," as determined under Code Section 414.

Retiree.

(a) Prior to July 1, 2000, a Retiree means:

- A full-time Employee who elects to retire from the Employer, has reached age 50, has at least one year of service (meaning he worked 1,000 hours in a calendar year), and whose sum of age and length of service at retirement is greater than or equal to 60;
- A full-time faculty member who concludes Phased Retirement (as defined in the Employer's Phased Retirement Plan); or

- A member of a religious community assigned to serve at UDM and who meets the retirement eligibility guidelines of his community.
- (b) On and after February 1, 2003, a Retiree means:
- A full-time Employee who elects to retire from the Employer and who:
 - (I) is age 50 with 10 years of service;
 - (II) is age 55 with 5 years of service; or
 - (III) has 30 years of service; or
 - A full-time faculty member who elects to retire from the Employer, has attained at least age 55 and who concluded Phased Retirement from the Employer.
 - No Employee hired or rehired by the Employer after February 1, 2003 will become eligible for Medical or Prescription Drug benefits under the Plan as a Retiree.

Seasonal Employee. For purposes of medical and prescription drug benefit eligibility, a “Seasonal Employee” is a New Employee who is hired into a position for which the Employer determines the customary annual employment is six months or less, occurring at approximately the same time each year. For purposes of all other benefits under the Plan, a “Seasonal Employee” is an Employee who regularly works less than nine months of the year.

Spouse. The person to whom the Employee or Retiree is legally married, determined under the laws in effect in the jurisdiction in which the marriage was performed at the time of the marriage (including a person of the same-sex). A person ceases to be a Spouse upon legal separation or divorce. A common law spouse or any other person named as a spouse but not meeting this definition will not be considered a Spouse.

Standard Administrative Period. The 90-day period beginning on April 2nd each year and ending the following June 30th.

Standard Measurement Period. The 12-month period beginning April 2nd each year and ending the following April 1st.

Standard Stability Period. The 12-month period beginning July 1st each year and ending the following June 30th. The same Standard Stability Period applies with respect to Employees who are determined to be Full-Time Employees during the Standard Measurement Period and Employees who are determined not to be Full-Time Employees during the Standard Measurement Period.

Third Party Administrator. Any qualified agent contracted by UDM to administer the Plan, including a Claims Administrator.

Usual, Reasonable and Customary Charges, Fees and Expenses. The prevailing range of charges, fees and expenses charged by most Hospitals located in the same area (zip code or other as determined by the Plan) and by most Physicians and other Providers of similar training and experience located in the same area, taking into consideration any unusual circumstances of

the patient's condition that might require additional time, skill or experience to treat successfully. The Usual, Reasonable and Customary Charges, Fees and Expenses are the maximum allowed for covered services. The Plan reserves the right to determine such Usual, Reasonable and Customary Charges, Fees and Expenses.

USERRA. The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Variable-Hour Employee. A New Employee if, based on the facts and circumstances at the Employee's start date, the Employer cannot determine whether the Employee is reasonably expected to be employed on average at least 30 Hours of Service per week during the Initial Measurement Period because the Employee's weekly hours are expected to be variable or otherwise uncertain. For this purpose, the Employer may not take into account the likelihood that the Employee may terminate employment before the end of the Initial Measurement Period.

ARTICLE III PARTICIPATION

3.1 ELIGIBILITY.

The following individuals are eligible to participate in this Plan:

- Full-Time Employees;
- Retirees, to the extent set forth in Article V, the "Retiree Coverage" section of the Plan; and
- Dependents, as described below.

For purposes of eligibility for all benefits other than medical and prescription drug benefits, an Employee is not an eligible Employee if they are a seasonal employee who regularly works only a portion of each year that is less than nine months. Temporary employees hired for a limited period without guarantee of rehire or recall at the end of that period, students in training, and co-ops are also not eligible for any benefits other than medical and prescription drug benefits.

An Employee or Retiree's Spouse or Legally Domiciled Adult/Domestic Partner with access to group medical and prescription drug coverage through his or her employer must enroll in their employer's plan in order to be eligible to elect Medical and Prescription Drug coverage under this Plan, unless the employee-portion of the premium cost for coverage under such employer's plan exceeds \$175 per month. Where coverage is provided under the other employer's plan it will be primary and this Plan will provide only secondary coverage.

Only one Legally Domiciled Adult of an Employee/Retiree may participate in the Plan at a time. No Spouse, Domestic Partner, Dependent Child, or Disabled Dependent is considered a Legally Domiciled Adult subject to this limit.

Disabled Dependent(s) are eligible for coverage if the Employer and the Third Party Administrator are first notified in writing before the end of the calendar year in which the child turns 26 of the desire to obtain coverage as a Disabled Dependent. The Plan reserves the right

to review the status of disabled dependents from time to time in order to verify their eligibility for coverage.

Proof of dependence and placement for adoption, if applicable, must be provided to the Employer upon request.

NOTE: An Employee or Retiree who is also a Spouse of another Employee or Retiree may be covered either as a Dependent or as an Employee/Retiree, but may not be covered as both a Dependent and as an Employee/Retiree. An Employee who is also a Dependent Child of another Employee may be covered as an Employee or be covered as a Dependent Child of the other Employee. A child who is a Dependent of two Employees may only be covered as the Dependent of one of the Employees and may not be covered as a Dependent of both Employees. Except as otherwise specifically provided herein to the contrary, a Spouse, a Dependent Child, or Disabled Dependent shall cease to be eligible for coverage when the Employee/Retiree ceases to be eligible for coverage.

3.2 **INITIAL ENROLLMENT PERIOD.**

A new Full-Time Employee is eligible to enroll in coverage effective the first day of the month following the first date of his or her full-time employment. An employee not hired as a Full-Time Employee is eligible to enroll in coverage effective as of the first day of the Stability Period following the Measurement Period for which they first are classified as a Full-Time Employee by the Employer. Except as specifically provided otherwise in the FMLA portion of the Plan, an eligible Employee may enroll himself and, if applicable, his Dependents in the Plan within 30 days of his becoming eligible (his "Initial Enrollment Period") by completing an enrollment form and an agreement to make such contributions to this Plan as may be required by the Plan Administrator from time to time. Contributions may be made to this Plan by an Employee through the Employer-sponsored cafeteria portion of the plan, within the meaning of Section 125 of the Code.

Even though an Employee may enroll during his Initial Enrollment Period, coverage and participation under this Plan will not commence until the Coverage Effective Date, as provided under Section 3.4.

If an Employee terminates employment and is rehired, he shall have a new Initial Enrollment Period ending 30 days after the date he becomes eligible, which begins on the first day of the month which follows a waiting period of 30 days from his reemployment commencement date. If the Employee incurs a new Initial Enrollment Period, participation in the Plan will not commence until the Coverage Effective Date, as provided under Section 3.4.

If either: (i) an individual who was employed by the Employer but is not an Employee, or (ii) an individual was employed by a Related Company that has not adopted the Plan, is transferred into service where he qualifies as an Employee, he shall be eligible to participate as of the first day of the month following the day of the transfer, provided that at least 30 days have passed from his date of hire by the Employer or the Related Company. Such an Employee shall have an Initial Enrollment Period in which he shall be entitled to enroll himself and his Dependents no later than 30 days after his eligibility date. In such case, participation will commence on the Coverage Effective Date under Section 3.4.

If an employee is not a full-time Employee, his Initial Enrollment Period will not commence until he becomes a full-time Employee.

NOTE: If the Employee does not enroll or reenroll, as applicable, himself and/or his Dependents during his Initial Enrollment Period, the Employee and/or Dependents, as applicable, will not be eligible to participate except in accordance with the enrollment procedures of Section 3.3 or as hereinafter provided.

If an Employee does not enroll or reenroll, as applicable, in the Plan, he shall be requested to state in writing, at the time coverage is declined, the reason for declining coverage. The Plan Administrator shall notify the Employee of the requirements of providing this statement and the effect of failing to provide this statement on subsequent eligibility of the Employee and his Dependents for enrollment upon a Change in Status, as described below.

Enrollment in the Wellness Program is automatic when the Employee is enrolled in medical benefits.

3.3 ENROLLMENT AFTER INITIAL ENROLLMENT PERIOD.

If an Employee or Dependent has not enrolled in the Plan within the Initial Enrollment Period, he may not be enrolled in the Plan until the next Open Enrollment Period, unless he has a Change in Status. In addition, unless there is a Change in Status, an Employee may not change coverage from single to family, from family to single, from single or family to single and one Dependent, or from single and one Dependent to family or single coverage before the next Open Enrollment Period. Initial enrollment requires completion of an enrollment form, agreeing to make the contributions required by the Plan.

Open Enrollment Period. The Open Enrollment Period is a period, usually in June, during which an Employee can enroll himself and/or his Dependent(s) in the Plan, or make changes to coverage. Changes made during Open Enrollment are effective for coverage during the 12-month period beginning on the following July 1. If you do not make any change to your prior elections during Open Enrollment, your prior elections will continue to apply, and you will automatically be deemed to agree to make the contributions required by the Plan.

Change in Status. After the Initial Enrollment Period has expired, you generally can change the elections you have made regarding Medical and Prescription Drug, Dental, and Vision, and Health FSA benefits (“Health Benefits”) for yourself or your Dependents, as applicable, only if there is a Change in Status.

A Change in Status occurs if a “Change in Status Event” occurs that results in the Employee or his Dependents gaining or losing eligibility for coverage under this Plan or another accident or health plan, or becoming eligible or ineligible for a particular benefit package option. A Change in Status that affects eligibility under a plan includes a Change in Status that results in an increase or decrease in the number of an Employee’s Dependents. When a Change in Status occurs, the election change must correspond with that gain or loss of coverage. The following events are change in status events:

- Marriage, divorce, death of a Spouse, legal separation or annulment;
- Change in the number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;
- Any of the following events for you, your Spouse or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence that qualifies under the Family and Medical Leave Act

or the Uniformed Services Employment and Reemployment Rights Act, a change in worksite that affects your eligibility for benefits, or any other change in employment status that affects eligibility for benefits;

- One of your Dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, or any similar circumstance; and
- A change in the place of residence of you, your Spouse or Dependent that would lead to a change in status, such as moving out of a coverage area for insurance.
- In addition, if you are participating in the Dependent FSA benefit, then there is a change in status if your Dependent no longer meets the qualifications to be eligible for dependent care.

You must notify the Plan Administrator within 31 days if you marry your Domestic Partner. You cannot pay premiums for Domestic Partner coverage on a pre-tax basis and any employer-paid premiums result in imputed taxation. If they become your Spouse, however, these adverse tax consequences will no longer apply with respect to your former Domestic Partner.

You may also change your election in a manner that is consistent with the following circumstances:

For Medical, Prescription Drug, Dental, Vision, and for Health FSA benefits

- If you, your Spouse or your Dependent, are eligible for “Special Enrollment,” as described in the Plan document, for Medical, Prescription Drug or Dental Benefits, you may revoke your prior election and make a new election that corresponds with the special enrollment rights.
- If your Spouse or Dependent makes an election change under a benefits plan maintained by his or her employer, and the election change satisfies the election change rules of Internal Revenue Code Section 125 relating to cafeteria plans, you may change your election to correspond with that change. You may also make an election change to correspond with an election change made by your Spouse or Dependent during an open enrollment period, when the benefits plan of your Spouse’s or Dependent’s employer has a different period of coverage. In addition, if you, your Spouse or Dependent lose dental coverage under a group health plan sponsored by a governmental or educational institution, you may change your election under the Health FSA benefit.
- If a judgment, decree or order issued by a court or authorized state administrative agency resulting from a divorce, legal separation, annulment or change in legal custody requires someone else to provide health coverage for your Dependent child or foster child, and if coverage is actually provided for that child, you may change your Pre-tax Premium benefit election to cancel coverage for the child. If the judgment, order or decree requires you to provide the coverage, your election will automatically be changed to comply.
- If you, your Spouse, or Dependent gain or lose Governmental coverage, which includes only any group health coverage under a state's children's health insurance program (SCHIP) under Title XXI of the Social Security Act, a medical

care program of an Indian Tribal government (as defined in §7701(a)(40)), the Indian Health Service, or a tribal organization, a State health benefits risk pool, or a Foreign government group health plan, you may make a corresponding election on a prospective basis to drop or add coverage.

For Medical, Prescription Drug, Dental, and Vision Benefits

- If new benefits become available under the Plan, or if coverage under the Plan is significantly improved, you may make a corresponding change in election. If coverage under the Plan is significantly reduced or eliminated, you will be permitted to make a corresponding election change if these changes affect you. If you are not a Participant in this Plan at the time the Employer adds another benefit option, you may elect to join the Plan.
- If the coverage under a Plan benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive -- on a prospective basis -- coverage under another plan with similar coverage.

For Medical, Prescription Drug, and Health FSA Benefits

- If you, your Spouse or your Dependent lose entitlement to Medicare or Medicaid, you may change your Pre-tax Premium benefit and Health FSA benefit elections. If you, your Spouse or your Dependent become entitled to Medicare or Medicaid, you may change your Pre-tax Premium benefit and Health FSA benefit elections to reduce or cancel coverage.

For Pre-tax Premium and Dependent Care FSA Benefits

- If the cost of your benefits significantly increases, you may make a corresponding increase in your payments. You may also change your election to another benefit (if available) that provides similar coverage. If the cost of your benefits significantly decreases, you may also make a corresponding election change. However, you may only change your election for the Dependent Care FSA benefit if the cost increase is imposed by a dependent care provider who is not your relative. If the premium cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

For Dependent Care FSA Benefits

- An election change your Dependent Care FSA benefits may be made if your Dependent attains age 13, becomes totally disabled or ceases to be either physically or mentally incapable of self-care, or you change providers, resulting in a different cost (as long as the provider is not a relative).

These rules on change due to cost or coverage do not apply to the Health FSA benefit, and you may not change your election to the Health FSA benefit if you make a change due to cost or coverage for insurance.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your Spouse, or your Dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the cafeteria portion of this Plan. If any of these conditions apply to you, you should contact the Plan Administrator.

You must inform the Employer of your new election by completing and submitting a new election form and Compensation Reduction Agreement within 30 days (31 days when adding a new dependent to Medical and Prescription Drug Coverage; 60 days in the event of a gain or loss of Governmental coverage), of the occurrence of any of the Change in Status events listed above. Elections made within the applicable 30-day, 31-day, or 60-day period will be effective for the balance of the Plan Year of the new election beginning on the first pay period following the day you properly complete and submit the election.

If you have a change in status and revoke your election for the Health FSA benefit or the Dependent Care FSA benefit, you will be required to submit claims for the period prior to the change in status within 90 days of the end of the Plan Year (or by December 31st of the Plan Year if you terminate employment). Claims incurred after an election has been revoked due to a change in status will not be eligible for reimbursement except to the extent that a valid COBRA coverage election is in place with respect to the Health FSA benefit.

3.4 COVERAGE EFFECTIVE DATE.

Coverage for newly hired Employee and his Dependents shall become effective as of the first day of the month after his hire date, as long as the Employee has enrolled himself and his Dependents in the Plan within the Initial Enrollment Period as required under Section 3.2.

In the case of an Employee or Dependent who is enrolled in the Plan during a given Open Enrollment Period, the Employee's or Dependent's Medical and Prescription Drug coverage shall be effective on July 1 of the Plan Year immediately following the given Open Enrollment Period. Where an Employee enrolls in Health FSA or Dependent Care FSA benefits during an Open Enrollment Period, coverage for the next benefit year shall begin on the following January 1st.

In the case of an Employee or Dependent who is eligible to enroll in the Plan upon a Change in Status Event, Medical and Prescription Drug coverage shall become effective as of the date of the Change in Status Event, provided the Employee or Dependent is enrolled in the Plan within 30 days of a Change in Status Event (31 days when a Dependent is added to Medical and Prescription Drug coverage) or, if later, 31 days following the date a claim is denied due to operation of a lifetime limit on all benefits in the case of a Change in Status Event involving the application of a lifetime limit, or 60 days after a Change in Status Event involving gaining or losing eligibility for coverage or a subsidy under Medicaid or a state child health plan.

Subject to the terms of the "FMLA Coverage" portion of this Plan, if an Employee has a leave of absence or layoff and he extends his participation as provided in the Leaves of Absence portion of the Plan and the Employee returns to work before the period of his extended participation terminates, the Employee and any of his Dependents who were Participants immediately prior to the leave of absence or layoff shall be enrolled in the Plan as a regular Employee effective as of his reemployment commencement date. If required by the Plan Administrator, the Employee must first complete an enrollment or other form and agree to make such contributions to this Plan as may be required by the Plan Administrator.

If an Employee was not a Participant in the Plan prior to his break in coverage or if he was a Participant in the Plan but he has a break in coverage and he returns to work, Medical and Prescription Drug coverage for the Employee and his Dependents will become effective as of the first day of the month following the return to work date, as long as the Employee has enrolled himself, and his Dependents if applicable, in the Plan within the Initial Enrollment Period as required under Section 3.2.

If an individual becomes an Employee as a result of a transfer from a position with the Employer in which he was excluded from participation, or by reason of employment by a Related Company which has not adopted the Plan, Medical and Prescription Drug coverage will become effective as of the first day of the month after his transfer, as long as the Employer has enrolled himself, and his Dependents, if applicable, in the Plan within his Initial Enrollment Period as required under Section 3.2.

If an individual becomes an Employee as a result of a transfer from part-time to full-time status with the Employer, the Medical and Prescription Drug coverage under this Plan of such Employee and his Dependents shall become effective as of the first day of the month following the date of the status change, as long as the Employee has enrolled himself, and his Dependents, if applicable, in the Plan within his Initial Enrollment Period as required under Section 3.2.

If an Employee has a break in service, regardless of length, and he and any of his Dependents are enrolled in the Plan under COBRA during the entire period of the break in service, the Employee will not be required to complete an additional waiting period before reenrolling himself and those Dependents in the Plan upon the Employee's return to service with the Employer.

To the extent required by USERRA, if an Employee has a break in coverage by reason of service in the uniformed services, the Employee will not be required to complete an additional waiting period before reenrolling in the Plan.

In no instance shall a Dependent's coverage become effective before the Employee's coverage becomes effective.

3.5 **COVERAGE TERMINATION.**

Participants. A Participant's coverage under the Plan shall terminate on the earliest of:

- For an Employee, the date the Employee ceases to be a member of a class eligible for coverage;
- For an Employee, the date of the Employee's termination of employment;
- The date of discontinuance of the Plan or the part of the Plan providing coverage for the Participant;
- The date the Participant presents a fraudulent or partially fraudulent claim for benefits under the Plan, and/or the date on which the Participant deliberately falsifies information on a benefit claim form. This termination of coverage can be imposed even in cases where a Physician prescribes treatment;
- The end of the period for which contributions have been made, if the Participant fails to make any required payments;

- The date the Participant elects to discontinue coverage in accordance with the terms of the Plan.

NOTE: The Plan may, but is not required to, offer a conversion policy following termination, which policy may provide such benefits as may be determined from time to time by the Employer and an insurer.

Dependents. A Dependent's coverage under the Plan terminates on the earliest of:

- The date the Plan ceases to offer Dependent coverage;
- The date a Dependent becomes covered as an Employee;
- The date the Dependent ceases to meet the Plan's definition of a Dependent;
- If the Dependent is Disabled Child, the date the Dependent is married;
- The date the Employee's or Retiree's coverage terminates, except as provided in the Leaves of Absence section of the Plan.
- The date the Employee/Retiree and/or the Dependent presents a fraudulent or partially fraudulent claim for benefits under the Plan and/or the date the Employee/Retiree and/or the Dependent deliberately falsifies information on a benefit claim form, as provided elsewhere below;
- The date the Employee/Retiree or the Dependent of an Employee/Retiree elects to discontinue the Dependent's coverage in accordance with the terms of the Plan;
- The date on which the Employee/Retiree fails to make a required contribution;
- The date the Dependent dies;
- Except as provided elsewhere below, the date on which the Retiree/Totally Disabled Employee dies.

Retirees. A Retiree's Medical benefit coverage terminates on the earliest of:

- The date of discontinuance of the Plan or the part of the Plan providing Retiree Medical benefits coverage;
- The date the Retiree and/or a Dependent presents a fraudulent or partially fraudulent claim for benefits under the Plan and/or the date the Retiree and/or a Dependent deliberately falsifies information on a benefit claim form, as provided elsewhere below;
- The end of the period for which a required contribution has been made for such coverage, if the Retiree fails to make any required payments; or
- The date the Retiree elects to discontinue coverage in accordance with the terms of the Plan.

Surviving Dependents. A Surviving Dependent's Medical benefit coverage terminates on the earliest of:

- The date of discontinuance of the Plan or the part of the Plan providing Surviving Dependent Medical benefit coverage;
- The date the Surviving Dependent presents a fraudulent or partially fraudulent claim for benefits under the Plan and/or the date the Surviving Dependent deliberately falsifies information on a benefit claim form, as provided elsewhere below;
- The end of the period for which a contribution has been made for such coverage, if the Surviving Dependent fails to make any required payments;
- The date the Surviving Dependent elects to discontinue coverage in accordance with the terms of the Plan;
- In the case of a Surviving Dependent spouse, the date the Surviving Dependent spouse remarries;
- The date the Dependent ceases to meet the definition of a Dependent under the Plan; or
- The date provided in the "Survivor Coverage" portion of the Leaves of Absence section the Plan.

3.6 NOTICE OF INELIGIBILITY.

In the event any Employee, former Employee, Retiree, surviving Dependent or any Dependent of any such individual is or becomes ineligible to participate in the Plan or in any extension of benefits under the Plan (such as under COBRA, USERRA or otherwise), the Employee, former Employee, Retiree, surviving Dependent and any Dependent of any such individual who becomes ineligible, shall immediately provide the Plan Administrator or its delegate with written notice of such ineligibility. Further, such individuals shall cease making claims for benefits under the Plan on behalf of any such ineligible individual. Failure to provide notice within 30 days of any event resulting in the ineligibility of any individual shall be governed by the following "Fraudulent Activities" provisions.

3.7 FRAUDULENT ACTIVITIES.

If a Participant or Dependent fails to provide notice as required under the preceding section, or permits any person who is not a Participant to use any identification card issued by the Third Party Administrator or otherwise fraudulently claims a benefit or falsifies information on a benefit claim form for himself or any Dependent, the Plan Administrator, or its delegate, may give the Participant written notice that such Participant and/or his Dependent (as determined in the sole discretion of the Plan Administrator) is no longer a covered person for benefits under the Plan. Following issuance of this written notice:

- The Participant and/or the Dependent, as applicable, will cease to be eligible for benefits under the Plan as of the date specified by the Plan Administrator in such written notice; and

- No benefits will be paid to the Participant under the Plan after that date with respect to the Participant and/or his Dependent.

Any action by the Plan Administrator, or its delegate, under these provisions is subject to review in accordance with the Claims, Claims Appeals and External Claims Review Procedures under the Plan.

ARTICLE IV LEAVES OF ABSENCES

4.1 FMLA LEAVE.

If you meet certain service requirements, you may be entitled to take a maximum of 12 weeks of job protected leave in a 12 month period for specified family and medical reasons under the Family and Medical Leave Act of 1993 (“FMLA”). For more information, see the Employer’s FMLA policy, which has additional details on your rights and obligations under the FMLA.

If you take leave under FMLA, you will be entitled during your leave to continue your coverage under the Medical, Prescription Drug, Dental, Vision, and Health Flexible Spending Account portions of the Plan (together, the “Health Plan”) at the same coverage level in effect at the time of your leave. Continuation of your Health Plan benefits will only be provided if you pay your portion of the cost of coverage for these benefits, as explained below.

If you marry or adopt a new child (or you otherwise acquire a new Dependent) during your FMLA leave, your new Spouse or Dependent will also be eligible for coverage during your leave, provided that you continue your coverage under the Health Plan and such Spouse or Dependent meets the Health Plan’s eligibility requirements.

You will be responsible for paying the Employee-portion of the cost of Health Plan coverage for you and your eligible Spouse and Dependents at active Employee rates while you are on leave.

If you are receiving any payments from the Employer during your leave, then your portion of the cost of coverage will be deducted from such payments. If you are not receiving any such payments or if your payments are insufficient to cover your portion of the cost of coverage, then you will be required to make payments to the Employer for your portion of the cost of coverage by the regularly scheduled payment dates. You may elect:

- To make payments to the Employer on an after-tax basis on the same schedule as if the you were not on an FMLA leave;
- To make no payments until you return to work, and when you return to work the Employer may recover, by payroll deduction under the cafeteria portion of the Plan, from your available compensation, to the extent permitted under applicable law, any payments not made during FMLA leave; or
- To pre-pay from any taxable compensation payable to you (including the cashing out of sick days or vacation days); provided, however, that no pre-payment may

be made in a manner that will permit a pre-tax payment to be made in one tax year that will be applied to a subsequent tax year.

If your required payment is more than 30 days late, coverage for medical benefits during an FMLA leave will cease retroactively to the date the required payment was due, provided the Employer has given the Employee at least 15 days advance written notice that if payment is not received by the 30th day, coverage will be dropped on that date retroactive to the date the required payment is due. If the notice is not timely sent, coverage will cease 15 days after the required notice is given or the date specified in the notice, if later, unless the payment has been received by that date.

If medical coverage lapses due to failure of an Employee to timely make required payments, upon the Employee's return from FMLA leave, the Employer will restore the Employee and his Dependents to coverage under the Plan in the same manner and at the same levels as provided before the FMLA leave began, and subject to any changes in benefit levels that may have taken place affecting the entire workforce, unless otherwise elected by the Employee.

If any provision of this Plan would provide an Employee or his Dependents greater rights than the rights provided under the FMLA and this section of the Plan, the Employee and his Dependents will be entitled to the greater rights to the extent provided by the Plan; provided, however, that in the event an Employee who qualifies for FMLA leave also qualifies for an extension of participation in the Plan due to a different type of leave, the Employee's leave period automatically will be designated as an FMLA leave period and shall apply against an Employee's rights under the FMLA and the FMLA leave period shall be subtracted from any extension of participation otherwise required so as to eliminate all duplication of FMLA leave periods with other Plan leave periods.

When you return from FMLA leave, your Health Plan coverage will resume effective as of the date you return to work. No proof of good health will be required and no waiting period will be imposed.

While you are on an FMLA leave, other Plan benefits paid in full by the Employer will continue. Other Plan benefits for which you have a required contribution will only continue if you pay your required contribution while on the FMLA leave. Whether you continue your benefits or not while on FMLA leave, when you return to work, you will be reinstated into all the benefits programs in which you participated prior to your FMLA leave.

4.2 USERRA/MILITARY LEAVES OF ABSENCE.

If you, your Spouse, or another covered Dependent loses Plan coverage as a result of your qualifying service in the uniformed services (your performance of duty in the Armed Forces (including the Coast Guard, the Reserves, the Army National Guard, the Air National Guard, and the commissioned corps of the Public Health Service) and you provide advance notice of your service (unless such notice is excused), you have the right to elect to continue coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Your right to continued Plan coverage under USERRA is very similar, but not identical, to your right to continued health coverage under COBRA. Your right to COBRA continuation coverage is described in the COBRA section of this basic Plan document. In those instances where your rights under COBRA and USERRA are not the same, whichever law gives you the greater benefit will apply.

The administrative policies and procedures that govern your right to COBRA continuation coverage (as described in the COBRA Continuation Coverage section) also apply to your right to USERRA continuation coverage, with a few limited exceptions described below.

Election of USERRA Continuation Coverage. The procedures for electing USERRA continuation coverage are the same as the procedures for electing COBRA continuation coverage. (These procedures are described in the COBRA section.) Any election that you make under COBRA will also be an election to continue your Plan coverage under USERRA. In other words, if you elect to continue Plan coverage under COBRA by completing and returning a COBRA election form within the required time period, you will be deemed to have elected to continue your coverage under USERRA. If, however, you are unable to elect COBRA within the required period because of military necessity or because it is impossible or unreasonable for you to do so, the period for electing USERRA coverage will be suspended until the military necessity is abated or it is no longer impossible or unreasonable for you to make the required election. The period for electing COBRA continuation coverage, however, will not be suspended in this situation.

Only the covered Employee who is called to serve in the uniformed services may make an election under USERRA to continue coverage for the Employee or any covered Dependents, or both. Dependents do not have an independent right to make an election for USERRA continuation coverage. As a result, if you do not elect USERRA/COBRA coverage on behalf of your Dependents, your covered Dependents will still have a right to elect to continue their coverage under COBRA, but they will not be entitled to receive any additional benefits provided under USERRA.

If you elect to continue coverage under USERRA, generally, you will be provided the same coverage that was in effect when your military service began. From time to time, however, some changes in coverage and cost are possible. For example, coverage and cost may be modified as the Plan makes regular changes to the Plan, and you will be given the opportunity to make a new election during annual enrollment or when you have a qualifying event.

Payment for USERRA Coverage. If you elect to continue coverage under USERRA, you will be required to pay 102% of the full premium (both Employer and Employee portions) for the coverage elected. This is the same premium rate as COBRA. However, if your uniformed service period is less than 31 days, you are not required to pay more for coverage than you would be required to pay as an active covered Employee.

You must make your payments for USERRA coverage at the times and according to the same procedures that apply to payment of COBRA continuation coverage. These time periods and procedures are described in the COBRA section. For example, you must make your initial premium payment within 45 days of electing USERRA/COBRA coverage, and thereafter you must make your monthly premium payments within 30 days of the due date.

Duration of USERRA Coverage. If you elect to continue health coverage for yourself and/or your covered Dependents under USERRA and you remit your payment for coverage on time, coverage will begin on the day after health coverage is lost under the Plan. In other words, you will not experience an interruption in coverage. Thereafter, USERRA continuation coverage will terminate upon the earliest of the following events to occur:

- After 24 months of coverage;
- A premium payment is not made within the required time;

- You fail to return to work within the time required under USERRA following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Although COBRA continuation coverage and USERRA coverage begin at the same time, they do not end at the same time. COBRA continuation coverage continues for up to 18 months (although, if certain events occur, it can be extended), while USERRA coverage continues for up to 24 months as described above. On the other hand, there are certain events, like your failure to return to work at the end of your service or a dishonorable discharge, which cause your USERRA coverage to terminate early but which do not cause COBRA continuation coverage to terminate. In that situation, even if your USERRA coverage terminates, you may still be entitled to continued coverage under COBRA.

Right to Reinstatement. If you return to the employ of the Employer during the period you are entitled to reemployment rights under USERRA, regardless of whether you elect to continue coverage during your military service, you have the right to have your benefits under the Plan reinstated when you are reemployed by the Employer, generally without any waiting periods or pre-existing condition exclusions (except for service-connected illnesses or injuries).

If You Have Questions. Questions concerning your USERRA continuation coverage rights should be addressed to the Human Resources Department. For more information about your rights under USERRA, contact the U.S. Department of Labor's Veterans' Employment and Training Service (VETS) in your area or visit the VETS website at www.dol.gov/vets (addresses and phone numbers of state and regional VETS offices are available on the VETS website).

4.3 MEDICAL LEAVE OF ABSENCE.

If the Employee is on an approved medical leave of absence other than an FMLA leave, the coverage of the Employee and his Dependents, if any, will continue during the term of the medical leave for the lesser of 6 months, or the time-period that the Employee is receiving Short-Term Disability benefits, so long as the Employee pays the Employee-portion of the cost of the coverage the Employee has elected for himself and his Dependents. This extended coverage will not be considered COBRA coverage and will not be applied to the maximum COBRA duration period.

4.4 PERSONAL AND PROFESSIONAL LEAVES OF ABSENCE.

If the Employee is on a personal or professional Employer-approved leave of absence, other than Employer-approved medical leave, regular participation may be continued for a period not to exceed six months so long as the Employee pays the entire cost of the coverage elected by the Employee for himself and his Dependents. Coverage shall cease upon expiration of the leave of absence or the date the Employee ceases to make required contributions, if earlier. After such time, continuation of coverage shall be subject to the Plan's COBRA provisions.

ARTICLE V RETIREE AND SURVIVOR COVERAGE

5.1 RETIREE COVERAGE.

If an Employee becomes a Retiree, he may elect to extend his regular participation and the participation of his Dependents in group Medical and Prescription Drug coverage, to the extent such coverage is applicable to Retirees. If a new Retiree is Medicare Part B eligible, different coverage options apply. Additionally, if an Employee becomes a Retiree, he may elect to extend his regular participation and the participation of his Dependents in Dental benefits under the Plan for up to one year from the date of retirement. Coverage ends as described in Section 3.5. Once coverage ends, the Retiree is not able to reinstate his coverage under the Plan.

Extended coverage is subject to the following:

- Coverage must be elected no later than the date on which the Retiree first becomes eligible to continue his participation in the Plan in accordance with this section. A Retiree may not defer his participation until a later date.
- Coverage is in lieu of any COBRA coverage under the Plan to which the Retiree is otherwise entitled.
- Coverage will be continued for a Dependent of a Retiree only if each of the following conditions are met:
 - The Retiree has elected coverage for himself and the Dependent under this section in lieu of COBRA coverage, and the Dependent does not elect COBRA coverage;
 - The Dependent was covered under the Plan on the Retiree's last day of employment with the Employer. However, if a covered Retiree marries or acquires a Dependent through Marriage, birth or adoption, the following apply:
 - The Spouse of the Retiree may be enrolled for coverage within 30 days of Marriage, or upon a child becoming a Dependent of the Retiree through birth, adoption or placement for adoption.
 - The Dependent Child may be enrolled for coverage within 30 days of becoming a Dependent.
 - In the case of a Spouse who may be enrolled upon Marriage, coverage becomes effective as of the date of Marriage. In the case of a Spouse who may be enrolled upon the birth, adoption or placement for adoption of a Dependent, coverage of the Spouse becomes effective as of the date of the birth, adoption or placement for adoption, provided the Spouse is enrolled in the Plan as required. Except as above provided, a Retiree may not enroll a Spouse in the Plan.
 - Coverage of a Spouse terminates as provided in Section 3.6, unless the Spouse is eligible to receive survivor coverage under this section. However, if the coverage of a Spouse under this section terminates as a result of any event which

is deemed a “Qualifying Event” under COBRA, the Spouse has the right to continue coverage under COBRA for a 36-month period beginning after the date of the occurrence of the “Qualifying Event.”

- Once a Retiree or Dependent becomes eligible for Medicare, that individual’s coverage will be supplemental to Medicare and subject to the “Medicare” section of the Plan, unless such section provides that the individual is also eligible for regular coverage under this Plan.

Contribution Requirement for Retiree Coverage. Medical and Prescription Drug coverage for a Retiree and his Dependent(s) is contingent upon payment of a monthly contribution as determined from time to time by the Employer or the Plan Administrator. If the Retiree or Dependent fails to make payment of required monthly contributions, or otherwise does not continue contributions, coverage of such Retiree or Dependent, as applicable, will cease and such person may not thereafter again resume participation in the Plan under this section. Contributions are also subject to the following:

- In no event shall the Employer Medical and Prescription Drug premium cost for any Retiree or Dependent for any annual period occurring on or after January 1, 2003 exceed 125% of fiscal year 2003 costs for any Retiree or Dependent. Thereafter, a Retiree shall be responsible for paying 100% of the difference between the fiscal year costs and the 125% cap amount on Employer costs. Co-pays, coinsurance, and deductibles may also apply.

Retiree Coverage Following VESIP Continuation Period. Pursuant to the University of Detroit Mercy 2017 Voluntary Early Separation Incentive Program (VESIP), certain individuals are eligible to continue their active employee group medical, prescription drug, and/or dental coverages under this Plan for up to eighteen (18) months. Following the end of the VESIP continuation period:

- Individuals who are not eligible Retirees will not be eligible for Retiree medical, prescription drug, or dental coverage under the Plan. These individuals may have COBRA rights, depending on the relevant facts and circumstances.
- Individuals who are eligible Retirees will be eligible to elect Retiree medical and prescription drug coverage under the Plan, pursuant to the terms of this Article V.
- Individuals who are eligible Retirees will not be eligible to elect retiree dental benefits under the Plan. VESIP dental benefits are in lieu of Retiree dental benefits under the Plan.

5.2 SURVIVOR COVERAGE.

Upon the death of a Retiree who retired with Medical and Prescription Drug benefits on or after February 1, 2003, his surviving Dependents shall be eligible to continue the Medical and Prescription Drug benefit coverage, at the Retiree contribution rate as determined by the Employer or the Plan Administrator from time to time. Coverage under this Section 5.2 will continue until the Dependent timely elects COBRA coverage under the Plan, if eligible, unless coverage terminates earlier under Section 3.5. Notwithstanding anything stated elsewhere in this Section 5.2, a Legally Domiciled Adult/Domestic Partner is not entitled to separately elect COBRA continuation coverage. Continuation coverage will be made available for a Legally Domiciled Adult/Domestic Partner if the Retiree elects COBRA continuation coverage, and such individual’s coverage ends when the Retiree’s COBRA coverage ends. The Retiree’s qualification for

Medicare or the death of the Retiree will not be a second qualifying event for a Legally Domiciled Adult/Domestic Partner.

The Dependent of a deceased Retiree may elect this continuation of coverage within 60 days subsequent to the death of the Retiree. If coverage is not timely elected or is thereafter terminated, the Dependent shall not be permitted to re-enroll in the Plan under this Section 5.3, but the Dependent of a deceased Retiree may be permitted to elect COBRA coverage if eligible and the COBRA election period has not then expired.

If a Dependent of a deceased Retiree ceases to be eligible for coverage under this Section 5.2, such Dependent may elect during the COBRA election period to continue coverage as a COBRA continuee to the extent permitted under the terms the Plan for the maximum period permitted under COBRA. Any extended coverage provided under this Section 5.2 will be considered COBRA coverage and will be applied toward the maximum COBRA duration period.

Once a Dependent of a deceased Retiree becomes eligible for Medicare, the Dependent's coverage will be supplemental to Medicare and subject to the "Medicare" section of the Plan, unless the individual is eligible for regular coverage under the Plan.

Effective for Retirees who retire with Medical and Prescription Drug benefits on or after July 1, 2016, the provisions of this section 5.2 only apply for a surviving Spouse, and not for other Dependents.

5.3 MEDICARE.

Group Medical and Prescription Drug coverage is available for certain Medicare-eligible individuals, as follows:

Health Coverage For An Employee Age 65 or Older or Disabled. An Employee who is age 65 or older or who is disabled and eligible for benefits under Medicare, has a choice of carriers for primary health care coverage. If the Employee otherwise is a Participant in the Plan, he may elect to have coverage for himself and his Dependents under this Plan as the primary payor or may choose Medicare as the primary payor.

If the Employee chooses this Plan as the primary payor, this Plan will pay the same benefits as if the Employee were under age 65 or not disabled, and any unpaid portion of the bill should be submitted to Medicare for consideration. However, if the Employee chooses Medicare to be the primary payor, this Plan only may provide benefits for those expenses that Medicare does not cover at all. The choice is the Employee's, and the Employee should contact the location Benefits Representative for information about making the primary/secondary designation. If the Employee does not make such primary/secondary designation, he shall be deemed to have elected that the Plan be the primary payor.

Health Coverage For An Employee's Spouse or Dependent Age 65 or Older or Disabled. A Spouse or other Dependent of an Employee who is age 65 or older or who is disabled and eligible for benefits under Medicare, has the opportunity to elect either this Plan or Medicare as the primary payor for himself, provided the Employee is a Participant in this Plan.

If the Spouse or other Dependent chooses this Plan to be the primary payor, this Plan will pay the same benefits as if the Spouse or other Dependent were under age 65 or not disabled, and any unpaid portion of the bill should be submitted to Medicare for consideration. However, if the Spouse or other Dependent chooses Medicare to be the primary payor, this Plan may only

provide benefits for those expenses that Medicare does not cover at all. The Employee should contact the location Benefits Representative for information about making the primary/secondary designation. If the Spouse or other Dependent does not make such primary/secondary designation, the Spouse or other Dependent shall be deemed to have elected that the Plan be the primary payor.

The Employee should contact his Social Security Administration Office for information and Medicare enrollment if he and/or his Dependent(s) are approaching age 65 or if he is under age 65 but becomes eligible for Medicare coverage because of disability. The Employee and/or Dependent(s) are encouraged to enroll for Medicare coverage 90 days before their 65th birthdays or during any Medicare open enrollment period.

Coverage for Retirees, their Dependents and the Dependents of Deceased Employees or Deceased Retirees upon Attaining Age 65 or Eligibility for Medicare. When a Retiree, a Dependent, a Dependent of a deceased Employee or a Dependent of a deceased Retiree, who is eligible for continuing coverage under this Plan, reaches age 65 or becomes eligible for Medicare, the Medical benefit coverage such Retiree or Dependent is entitled to under this Plan shall continue to the extent provided under an applicable Benefit Booklet, subject to the following:

- Coverage is contingent upon payment by such Retiree or Dependent of such monthly contribution, if any, as determined from time to time by the Employer or Plan Administrator. If required monthly contributions are not made, coverage for the Retiree or Dependent will cease and he may not thereafter again resume participation in the Plan.
- Coverage of a Retiree and a Dependent will cease as provided in Section 3.6, except that coverage of a Dependent will not cease solely due to failure to meet the Plan's definition of Spouse as a result of the Employee's death.
- Medicare will be the primary payor, and this Plan shall be the secondary payor of Medical benefits as described in the applicable Benefit Booklets.
- If a Retiree becomes subject to this subsection as a result of reaching age 65 and becoming eligible for Medicare, his Dependent if not subject to this subsection, will continue coverage under the Plan as set forth in Section 3.6, subject to payment of any required contributions at Retiree rates.
- Any Retiree or Dependent receiving Medicare benefits must notify the location Benefits Representative of Medicare to ensure the full utilization of any benefits available.
- In administering claims, it will be assumed that all Retirees and all Spouses who are eligible for Medicare are enrolled in both Part A (Hospital) and Part B (Medical) benefits. If an eligible person does not enroll for Parts A and B, then any expenses normally covered under Part A and B will be the liability of the individual.

End Stage Renal Disease. An Employee or his Dependent who is eligible for Medicare on the basis of end stage renal disease (ESRD) has the opportunity to elect this Plan or Medicare as the primary payor for himself for a period of 30 months following the date such Employee or Dependent becomes entitled to Medicare.

If the Employee or Dependent chooses this Plan to be the primary payor, this Plan will pay the same benefits as if the Employee or Dependent were not eligible for Medicare on the basis of

ESRD, and any unpaid portion of the bill should be submitted to Medicare for consideration. However, if the Employee or Dependent chooses Medicare to be the primary payor, this Plan may only provide benefits for those expenses that Medicare does not cover at all. The Employee should contact the location Benefits Representative for information about making the primary/secondary designation. If the Dependent does not make such primary/secondary designation, the Employee or Dependent shall be deemed to have elected that the Plan be the primary payor.

5.4 RIGHT TO AMEND OR TERMINATE.

The Employer reserves the right to amend the Plan in order to add, delete or modify any Plan benefit of any Retiree or Dependent of any Retiree, or otherwise change the terms of the Plan at any time without notice to the Retiree or Dependent of such Retiree except to the extent such amendment materially affects collectively bargained terms specifically applicable to such Retiree or Dependent of such Retiree. Any such amendment may be made without regard to the provisions of this Plan applicable from time to time to Employees and their Dependents. The right of the Employer to amend shall specifically include the right to terminate any portion or all of the coverage of any Retiree or Dependent even if such amendment is made after the retirement or termination of employment of such Employee. Further, the Employer reserves the right to establish Co-Payment and Co-Insurance requirements, Deductibles and premium contribution requirements for coverage as it determines in its sole discretion.

ARTICLE VI FLEXIBLE BENEFITS

6.1 OVERVIEW OF FLEXIBLE BENEFIT PROGRAM.

The Flexible Benefits Program portion of the Plan includes a cafeteria plan that provides the following benefit options:

Health Flexible Spending Account (“Health FSA”). Eligible Employees can elect to contribute to a Health FSA, and can receive up to the amount of their election from the Plan in reimbursement for qualifying expenses for medical, dental and vision care of the Employee, the Employee's Spouse and Dependents. Annual election amounts are limited to the maximum amounts permitted by law. The amounts paid under the Plan for such qualifying expenses are not taxable to the Employee.

Dependent Care Flexible Spending Account (“Dependent Care FSA”). Eligible Employees can elect to contribute up to the maximum annual amount permitted by law, which can be applied to reimburse qualified expenses for the care of Dependent Children under 13 years of age (i.e. child care) or adult and elder daycare expenses for qualified dependent family members who are physically or mentally incapable of caring for themselves, to allow the Employee to work. The amounts so paid for dependent care are not taxable to the Employee.

Opt-Out Cash Benefit. Eligible Employees may elect to waive the Medical and Prescription Drug benefits under the Plan for which they are eligible and receive instead optional cash payments,

as a supplement to their regular cash compensation. Opt-out Cash Benefits are subject to tax, just like regular employment compensation.

Pre-Tax Premium Benefit. Eligible Employees can use pre-tax compensation to pay Employee premiums for certain premiums associated with insurance coverage elected under the Plan, which currently include Medical and Prescription Drug coverage premiums.

Pre-Tax HSA Contributions. Eligible Employees can use pre-tax compensation to contribute to a Health Savings Account that they select.

These benefits are described more fully below.

6.2 FLEXIBLE BENEFITS - CAFETERIA PLAN

A cafeteria plan is a plan that offers Employees a choice of two or more permitted optional benefits, one of which must be cash (or a taxable benefit) and one of which must be a non-taxable benefit. A cafeteria plan must comply with the requirements of Section 125 of the Internal Revenue Code in order for the election of a benefit by the Employee to not constitute a taxable event.

Participation in the Flexible Benefits Portion of the Plan. Once you are eligible to participate in the Plan, you will be provided with information concerning the Flexible Benefits available through the cafeteria portion of the Plan, and an election form with a Compensation Reduction Agreement, to elect to have a designated amount of the compensation otherwise payable to you used to provide the elected benefits.

Compensation Reduction Agreements. A Compensation Reduction Agreement is a written agreement you enter into with the Employer in which you agree to have compensation which the Employer would otherwise be paying you reduced by a specified dollar amount or percentage (in whole or half percentage amounts) and the Employer in turn agrees to make contributions or provide benefits under the Plan for the Flexible Benefits designated in the Compensation Reduction Agreement. Entering into an Agreement is purely voluntary on your part, and has no bearing on your employment or on your entitlement to any non-elective benefits provided by the Employer.

An election during open enrollment may only be made effective as of the beginning of the Benefit Year. If you are first eligible after the beginning of the Benefit Year, your initial election will generally only be effective as of the beginning of the first payroll period after you become eligible. The Compensation Reduction Agreement should be submitted to the Employer for acceptance in advance. The Compensation Reduction Agreement can only apply to compensation that you earn after it goes into effect, and cannot apply to compensation earned earlier. The reduction will be reflected in your paychecks from the Employer subsequent to the effective date and as long as such Agreement remains in effect. In other words, when your compensation is reduced pursuant to a Compensation Reduction Agreement, your regular paychecks will thereafter be computed on the basis of the reduced compensation amount. This compensation reduction is a reduction in your taxable income for both federal income and FICA purposes, thereby reducing those taxes; however, such amount is added back to your compensation for purposes of determining your allocated share of any contributions to Employer-sponsored retirement plans, so that you are not penalized for purposes of these other plans by elections made under the Flexible Benefits portion of the Plan.

Once you have entered into a Compensation Reduction Agreement, it remains in effect until revoked or modified by you, or until you cease to be employed by the Employer. You will be provided the opportunity during open enrollment each year to make a new Compensation Reduction Agreement for the following year, but if you do not make such a new Agreement, the existing one will automatically remain in effect.

Changing Elections Mid-Year. You generally cannot change the Flexible Benefit elections you have made after the beginning of the Benefit Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "Change in Status" and you make an election change that is consistent with the Change in Status. See Section 3.3 of the Plan for a discussion of Change in Status events.

Limits On Compensation Reduction Amounts. The maximum amount that you may elect to reduce your compensation under a Compensation Reduction Agreement for any Benefit Year is the lesser of the sum of the maximum that applies for each of the benefits elected, or 100% of the compensation payable to you by the Employer for the Plan Year subsequent to the date your Compensation Reduction Agreement goes into effect.

The maximums for the following available benefits are as follows:

- **Health FSA.** The maximum benefit is set by the Internal Revenue Code, and changes periodically – for 2023 the maximum compensation reduction contribution is \$2,850. This amount will change year to year based on the IRS maximum allowed, and will be communicated prior to the time of your election. The Plan also imposes a minimum contribution reduction amount of \$60 per Benefit Year.
- **Dependent Care FSA.** The maximum benefit is set by Section 129 of the Internal Revenue Code, and changes periodically. – for 2019 the maximum compensation reduction contribution is \$5,000.00, (or 50% of your Earned Income for the Year, if less) except that if you are married and you and your Spouse file separate (rather than a joint) income tax returns, the maximum is \$2,500.00 (or 50% of your Earned Income for the Year, or your Spouse's Earned Income, whichever is least). This amount will change year to year based on the IRS maximum allowed, and will be communicated prior to the time of your election. The Plan also imposes a minimum contribution reduction amount of \$60 per Benefit Year.

Pre-Tax HSA Contributions. The maximum benefit is set by the Internal Revenue Code, and changes periodically – for 2023 the maximum compensation reduction contribution is \$3,850 for an eligible Employee that elected single HDHP coverage, and \$7,7500 for an eligible Employee that elected family HDHP coverage. Participants age 55 or older may also elect to make catch up Pre-Tax HSA Contributions up to the statutory maximum amount (for 2023: \$1,000). These amounts will change year to year based on the IRS maximum allowed, and will be communicated prior to the time of your election. These amounts are also reduced by any employer HSA contributions for the year.

HEALTH FSA BENEFITS

The Flexible Benefit portion of the Plan includes a health flexible spending account option. The Health FSA is an expense reimbursement program designed to pay certain Qualified Medical Expenses as a tax-free fringe benefit. Qualified Medical Expenses are those that qualify as deductible medical expenses under Section 213 of the Internal Revenue Code for the Employee, the Employee's Spouse, or the Employee's Dependent children (including natural, adopted, foster, and step children) through the end of the year that they turn age 26.

The Medical, Prescription Drug, Dental, and Optical insurance offered under the Plan does not cover certain Qualified Medical Expenses such as deductibles, co-pays, coinsurance amounts, orthodontic expenses, special nursing services, special equipment necessitated by a medical condition, medications of certain types, transportation to obtain medical care, and expenses in excess of those the insurance carriers will pay (e.g., non-covered out-of-network expenses). Qualified Medical Expenses paid through the Health FSA program are in effect paid with pre-tax rather than after-tax dollars since the payment of such expenses by the Plan does not result in taxable income to the Employee.

Any Eligible Employee may elect to participate in the Health FSA benefit by completing a Compensation Reduction Agreement that allocates a portion of the Employee's compensation to the Employee's account under the cafeteria portion of the Plan. This election applies prospectively for the Benefit Year, and cannot be revoked mid-year, except as describe above in the section titled "*Changing Elections Mid-Year.*" However, an election regarding a future Benefit Year may be changed before the beginning of that Plan Year. If you do not file a new Compensation Reduction Agreement during the annual Open Enrollment period, your previously filed Compensation Reduction Agreement will be deemed to terminate for the next Benefit Year with respect to any Health FSA or Dependent Care FSA, but your Pre-Tax Premium benefit elections will automatically be made on your behalf in the amount of your required premiums toward coverage you elect or are deemed to have elected for Medical, Dental and Optical coverage, unless you affirmatively elect to pay on an after-tax basis. The Employer will reduce your compensation for the Benefit Year by the amount you elect to be applied to the Health FSA benefit, and will credit the full amount of your election to a hypothetical bookkeeping account under the Health FSA program. Qualifying expenses will be charged against this account.

Qualifying Health FSA Expenses. The Plan pays covered medical expenses for medical care for the Employee, the Employee's Spouse, and the Employee's Dependent unmarried children (which includes natural, adopted, foster, and step children) through the end of the year that they turn age 26, incurred during the Benefit Year. The general purpose Health FSA pays benefits up to the maximum amount of the Employee's Compensation Reduction for the year allocated to the Health FSA portion of the Plan. Medical care means expenses incurred for the following types of medical care, within the meaning of Section 213 of the Internal Revenue Code:

- (a) the diagnosis, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body;

- (b) transportation, such as ambulance, hired primarily for and essential to obtaining the medical care described in (a) above;
- (c) lodging while away from home primarily for and essential to obtaining the medical care described in (a) above, provided by a physician in a licensed hospital or equivalent medical care facility, not to exceed the maximum amount allowable as a deductible medical expense under Section 213(d)(2) of the Internal Revenue Code;
- (d) prescription drugs and insulin;
- (e) prosthesis.

Covered medical expenses reimbursable under the Plan are:

- (a) all those medical care expenses set forth in the insuring provisions of group insurance under the Plan which covers its Employees who meet minimum service requirements (and their Spouses and Dependent children) for hospital expenses, medical expenses, dental expenses, optical expenses, or prescription drug expenses, which cover the Employee;
- (b) the amount of any deductible under any group medical, dental, or vision insurance under the Plan;
- (c) any portion of any co-insurance that may be required of the Employee under any group medical, dental, or vision insurance under the Plan;
- (d) any other medical care expenses not covered by group insurance under the Plan;
- (e) Over-the-counter ("OTC") drugs.

Reimbursement for OTC drugs will be permitted only if the purchase is substantiated by a pharmacy receipt verifying the patient, the date, the amount of the purchase and a prescription drug number. This rule does not apply to insulin, which will continue to be a reimbursable medical expense whether or not it is purchased with a prescription. Medical supplies, equipment and diagnostic devices such as prescription eye glasses, crutches and blood sugar test kits continue to qualify as reimbursable medical care and are eligible for reimbursement from your medical reimbursement account.

Covered medical expenses specifically exclude any costs incurred as a result of penalties for abuse of cost containment provisions (such as hospital pre-admission authorization for elective surgery) of any group medical insurance plan.

Any covered medical expense which is covered by any medical insurance, whether under a policy provided under the Plan, or the Employee or the Spouse or Dependent of the Employee, or by Medicare, or by any other health or accident plan providing coverage to the Employee or the Employee's Spouse or Dependent, is not subject to reimbursement under the Plan to the extent of the coverage. If you subsequently recover any expense paid by the Plan from some other party, whether as a result of litigation, negotiation, or the making of a claim, you are required to reimburse the Plan.

Claims Process to Obtain Health FSA Benefits¹. Within 2 ½ months after the end of the Benefit Year, you must submit to the Claims Administrator any claims for benefits payable from the Health FSA portion of the Plan.

No advance payment can be made for care that is to be provided in a subsequent Benefit Year. The Claims Administrator may require submission of appropriate information or materials which he reasonably believes are needed in order to determine the eligibility of such expense for payment or reimbursement under the Plan.

All benefits approved for payment by the Claims Administrator will either be paid directly to the person or entity providing the covered medical care or insurance coverage, or they will be reimbursed to the Employee if the Employee has paid the expense, up to the Employee's remaining account balance. No separate fund is maintained for funding or paying such benefits. However, the Claims Administrator will maintain a bookkeeping account that reflects your Health FSA election and the amount of Health FSA benefits paid on your account. The benefits payable on your behalf cannot exceed at any time the annual amount you elect for the Benefit Year, reduced by all benefits previously paid for you for that Benefit Year.

The Claims Administrator will notify you in writing of any determination made denying requested benefits and the basis for such decision, and describing any further documentation required to substantiate your right to such benefits. If you believe the Claims Administrator's decision is not correct, you may review any pertinent documentation in the hands of the Employer or the Claims Administrator, and file a written request within 60 days for a review of such decision by the Claims Administrator. In connection with such review, you may make a presentation to the Claims Administrator in writing or in person or through a designated representative in support of your position. The Claims Administrator will give you a written decision on such review within 60 days following such presentation, setting forth the specific Plan provisions on which the decision is based.

The Claims Administrator will provide you with a statement of your account periodically during the Benefit Year.

Forfeiture of Unused Amounts. In the event that you do not use up your Health FSA account balance for the Benefit Year, any remaining unused amount will be applied to pay qualified expenses incurred during that Benefit Year and submitted by you for payment. Claims incurred during the first 2 ½ months following the end of a Benefit Year (the Grace Period) will then be payable from any remaining unused Health FSA account balance. There is no additional carry-over of unused benefits to a subsequent Benefit Year beyond the Grace Period, or any restoration to you of the amount of your compensation reduction for which you did not receive an expense reimbursement under the Plan. All claims must be submitted within ninety days after the end of the Benefit Year. Remaining unused amounts are forfeited at that time.

If your employment terminates during the Benefit Year for any reason, no payment shall be made for any expenses incurred after your termination of employment, or for expenses submitted for payment or reimbursement later than December 31 of the year of termination.

You may request from the Claims Administrator information as to the current unused amount in your benefit account under the Plan, and the Claims Administrator will attempt to notify you of any unused amounts shortly before the deadline for making use of such amounts, so you can submit appropriate expenses for payment before the deadline.

¹ See temporary provisions in Claims During Outbreak Period section.

Health FSA and Health Savings Account (“HSA”). No contributions can be made to an HSA in any month that you or your Spouse are participating in a Health FSA. This ineligibility regarding HSA contributions extends through the Health FSA’s grace period, unless your Health FSA account balance at the end of the calendar year prior to the start of the grace period was zero, or the Health FSA is a limited purpose (dental and/or vision expenses only) Health FSA.

Debit and Credit Cards. You may be provided a debit and/or credit stored value card (a “Card”) for payment of Qualified Medical Expenses. In the event you are issued a Card, you must certify that the Card will only be used for Qualified Medical Expenses, any expense paid with the card has not already been reimbursed by any other plan covering health benefits, and that you will not seek reimbursement from any other plan covering health benefits for the same expense. Your Card will be automatically cancelled upon your death or termination of employment, or if you have a change in status that results in your withdrawal from the Health Flexible Spending Account.

The maximum dollar amount of coverage available on the Card will be the applicable salary reduction amount you elected for the Plan Year. Cards may only be used for Qualified Medical Expense purchases including, but not limited to, the following:

- Deductibles, coinsurance and copayments for doctor and other medical care;
- Purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed under IRS regulations; and
- Purchase of medical items such as eyeglasses, syringes, crutches, etc.

Payments made using a Card are subject to substantiation, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Claims Administrator will follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69, as subsequently amended. All charges shall be conditional pending confirmation and substantiation.

If the Claims Administrator determines a payment was not for a Qualified Medical Expense or was not properly substantiated, the Administrator may use the following correction methods to make the Plan whole.

- Repayment of the improper amount by the Participant;
- Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;
- Claims substitution or offset of future claims until the amount is repaid; and
- if those methods are unsuccessful, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the Card.

Treatment of Benefits. Your Flexible Benefits are not taxable to the extent they do not exceed your maximum allowable benefits for the Benefit Year. However, under certain limited circumstances, if your annual compensation from the Employer for the Benefit Year puts you within the top 25% of all of the Employer's Employees or in the top 5% of the Employer's officers, and your benefits under the Flexible Benefits portion of the Plan exceed those available to other eligible Employees, the excess benefits are taxable.

When the Plan pays expenses that you could have otherwise deducted on your income tax return, those expenses may not be claimed as a deduction because there is no out-of-pocket expense to you.

Also, any benefits payable under insurance policies on which premiums have been paid under the Plan, except for medical care expenses deductible as such on your income tax return if paid by you and payments for loss of body member or function or permanent disfigurement, will constitute taxable income to you when received even though such benefits would not be taxable income to you if you had paid the premiums on such policy with after-tax dollars rather than through the Plan. You should take this into consideration in deciding whether to submit such premium to the Plan for payment or reimbursement. If you decide to pay premiums in after-tax dollars rather than through the Plan, so the benefits are not taxable, you can still have the Employer pay the premium on your behalf by a voluntary payroll deduction.

COBRA Continuation Rights.² The Health FSA benefit is the only benefit available under the Flexible Benefits Program portion of the Plan that is subject to COBRA continuation coverage. The provisions elsewhere in this Plan regarding COBRA Continuation Coverage apply, however the following special rules also apply to the Health FSA.

COBRA continuation coverage is only available if a Qualified Beneficiary makes a timely election of such coverage. An election is timely if it is made during the election period. The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Program. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

You can elect to continue your participation in the Health FSA benefit for the remainder of the Benefit Year, subject to the following conditions.

- You may only continue to participate in the Health FSA benefit if you have elected to contribute more money than you have taken out in claims.

Example: Assume you elected to contribute an annual amount of \$500 and, at the time you terminate employment, you have contributed \$300. If you only claimed \$150 through your termination date, you may elect to continue coverage under the Health FSA benefit because your claims were less than your annual election amount (plus any carryover). If you elect COBRA continuation coverage, then you would be able to continue to receive your health reimbursements up to the \$500. However, you must continue to pay for the coverage, just as the money was taken out of your paycheck before your termination, but on an after-tax basis. The Company can also charge you an extra amount (for administrative costs) to provide this benefit.

² See temporary provisions in Claims During Outbreak Period section.

- You cannot elect to continue your participation in the Health FSA if the maximum COBRA premium that can be charged for the remainder of the Benefit Year equals or exceeds the maximum benefit available for the remainder of the Benefit Year.

Example: Assume you elected to contribute an annual amount of \$1,200 and your employment terminates on June 30th after having contributed \$600 to the Health FSA benefit. If you received reimbursements of \$800 before termination, you are not eligible to elect COBRA continuation coverage of the Health FSA benefit. Your maximum COBRA premium of \$612 (\$100 monthly for 6 months plus the 2% COBRA administrative charge), exceeds your maximum reimbursement still available of \$400 (\$1,200 maximum less \$800 received).

Nondiscrimination Requirements. It is the intent of this Health Flexible Spending Account not to discriminate in violation of the Tax Code. If the Plan Administrator deems it necessary to avoid discrimination under the Health Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or benefits in order to assure compliance with this section. Any act taken by the Plan Administrator will be carried out in a uniform and nondiscriminatory manner. If the Plan Administrator decides to reject any elections or reduce contributions or benefits, it shall be done in the following manner. First, the Health Flexible Spending Account election of the Employee that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in the Tax Code are satisfied, or until the amount designated for the Health FSA election equals the amount designated by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Flexible Spending Account for the Benefit Year. This process will continue until the nondiscrimination tests set forth in the Tax Code are satisfied.

Qualified Reservist Distributions. A Participant may request a Qualified Reservist Distribution by submitting a request to the Claims Administrator, provided the following provisions are satisfied. "Qualified Reservist Distribution" means any distribution to a Participant of all or a portion of the balance in the Participant's Health Flexible Spending Account if:

- The Participant was an individual who was (by reason of being a member of a reserve component (as defined in Section 101 of Title 37, United States Code)) ordered or called to active duty for a period of 180 days or more or for an indefinite period.
- The distribution is made during the period beginning on the date of the order or call that applies to the Participant and ending on the last day of the Plan Year which includes the date of such order or call.
- The Participant is ordered or called to active duty, not the Participant's spouse or dependents.

"Reserve component" means: (1) the Army National Guard, (2) the Army Reserve, (3) the Navy Reserve, (4) the Marine Corps Reserve, (5) the Air National Guard, (6) the Air Force Reserve, (7) the Coast Guard Reserve, or (8) the Reserve Corps of the Public Health Service.

The Employer must receive a copy of the order or call to active duty and may rely on the order or call to determine the period that the Participant has been ordered or called to duty. Eligibility for a Qualified Reservist Distribution is not affected if the order or call is for 180 days or more or is indefinite, but the actual period of active duty is less than 180 days or is changed

otherwise from the order or call. If the original order is less than 180 days, then no Qualified Reservist Distribution is allowed. However, if subsequent calls or orders increase the total days of active duty to 180 or more, then a Qualified Reservist Distribution will be allowed.

The amount a Participant may be reimbursed from the Health Flexible Spending Account is the amount contributed by the Participant to the Health Flexible Spending Account as of the date of the distribution request, less any reimbursements received as of the date of the distribution request.

The number of distributions processed for a Participant is limited to 12 per Benefit Year. The distribution request must be made on or after the call or order, and before the last day of the Benefit Year. The QRD shall be paid within a reasonable time but in no event more than 60 days after the date of the request.

Claims incurred prior to the date of the request for the distribution will be paid as any other claim. Claims incurred after the date of the distribution will not be paid and the Participant's right to submit a claim terminates as of the date of the distribution request.

DEPENDENT CARE FSA BENEFITS

The purpose of the Dependent Care Flexible Spending Account ("Dependent Care FSA") portion of the Plan is to assist Employees who pay someone to care for their young child or children, or disabled dependent for whom the Employee has responsibility, in order to allow those Employees to work. The Dependent Care FSA was designed to comply with the requirements of Section 129 of the Internal Revenue Code.

Section 129 of the Internal Revenue Code provides that any amounts paid by an Employer for dependent care assistance, up to a prescribed maximum per year, are not includible in the gross income of the Employee, but rather are a tax-free fringe benefit. Qualifying dependent care assistance amounts are expenses paid for certain household services and for the care of dependents of the Employee who are either under age 13 or physically or mentally disabled who reside in the Employee's household, which expenses are incurred to enable the Employee to be gainfully employed (i.e. to be away from his or her household to meet employment responsibilities and still meet his or her responsibilities for care of such dependent who requires supervision or care). These expenses would otherwise qualify for a tax credit for the Employee under Section 21 of the Internal Revenue Code. Because of this, you should determine whether that tax credit would provide you a greater financial advantage than does the benefit of this Dependent Care FSA program.

Normally an Employee would have to pay for dependent care from his or her net income, after employment (FICA) and income taxes have been withheld. The Dependent Care FSA allows the Employee to elect to have his or her compensation from the Employer reduced, and the amount of the reduction is applied to pay the qualifying dependent care assistance expenses. This effectively means that qualifying expenses are paid with pre-tax rather than after-tax dollars,

since the payment of these expenses by the Employer does not result in any taxable income to you.

Benefits provided by the Dependent Care FSA portion of the Plan are only available to Employees who have dependent children under age 13, or an older disabled dependent, living in the Employee's household who requires full-time attention or care by another person while the Employee is at work, when the Employee does not have a Spouse or other dependent living in his or her household who can provide such care or supervision during work hours.

Compensation Reduction Agreements. To participate in the Dependent Care FSA benefit, you must enter into a Compensation Reduction Agreement whereby your compensation from the Employer is reduced by a prescribed amount, and that amount is available under the Plan to pay for qualified dependent care expenses.

Once you meet the eligibility requirements for participation in Plan, the Employer will provide you with a Compensation Reduction Agreement for use in making an election. This election is made during Open Enrollment, effective as of the beginning of the Benefit Year. An election, once made, may not be changed during the balance of the Benefit Year (except for certain changes in family status affecting the election, as described above in the section titled, "*Changing Elections Mid-Year*"). The election to participate should be submitted to the Employer at least 10 days before the date it can take effect. The Compensation Reduction Agreement can only apply to compensation that you earn after it goes into effect, and cannot apply to compensation earned earlier. The contracted for reduction will be reflected in your paychecks from the Employer subsequent to the effective date, for as long as the Agreement remains in effect. In other words, when your compensation is reduced pursuant to a Compensation Reduction Agreement, your regular paychecks will thereafter be computed on the basis of the reduced compensation amount. The compensation reduction is a reduction in your taxable income for purposes of both income and FICA withholding and taxation, thereby reducing those taxes, but it is added back to your compensation for purposes of determining your allocated share of any contributions to Employer-sponsored retirement plans, which allocations are based on your annual compensation. This means you are not penalized for purposes of these other plans by electing to participate in the Dependent Care FSA.

An amount equal to the amounts actually reduced from your compensation pursuant to a Compensation Reduction Agreement will be credited to a bookkeeping account. No interest or earnings are credited on these amounts. No actual account will be created, and all compensation reduction amounts will remain the property of the Employer. Your bookkeeping account credits will be reduced by an amount equal to the benefits paid for claims you submit to the Dependent Care FSA portion of the Plan.

Once you have entered into a Compensation Reduction Agreement, it remains in effect until revoked or modified by you, or until you cease to be employed by the Employer. You will be provided the opportunity during open enrollment each year to make a new Compensation Reduction Agreement for the following calendar year, but if you do not make such a new Agreement, the existing one will automatically remain in effect.

Benefits Available. The Plan pays qualifying expenses for dependent care, up to the amount by which your compensation has been reduced for such purpose under a Compensation Reduction Agreement.

A qualifying expense is an amount paid for:

- (a) expenses for the care of a qualifying individual, and
- (b) expenses for ordinary and necessary services performed at and which are necessary for the maintenance of the Employee's household and are attributable at least in part to the care of a qualifying individual residing in such household;

which expenses are incurred to enable the Employee to meet his or her work responsibilities for employment by the Employer, and would qualify for a dependent care tax credit under Section 21 of the Tax Code (disregarding any dollar or percentage limitations on such credit).

A qualifying individual for whom a qualifying expense is incurred is any of the following:

- (a) a dependent of the Employee who is under 13 years of age and for whom the Employee is entitled to a dependency exemption deduction on the Employee's United States income tax return for such Benefit Year - this could be a natural child, an adopted child, foster child, or a stepchild (if a dependent);
- (b) a dependent of the Employee who is 13 years of age or older (including an adult) who regularly spends at least 8 hours a day at the Employee's household who is physically or mentally incapable of caring for his or her hygiene or nutritional needs, or requires the full-time attention of another person for his or her own safety or the safety of others, and for whom the Employee is entitled to a personal exemption deduction on the Employee's United States income tax return for such Benefit Year - normally this would be a handicapped child, but could also be a handicapped or aged parent, grandparent, sibling, or other relative residing in the home of the Employee who qualifies as a dependent under Section 152 of the Tax Code;
- (c) the Spouse of the Employee if such Spouse is physically or mentally incapable of caring for his or her hygiene or nutritional needs, or requires the full-time attention of another person for his or her own safety or the safety of others, and who regularly spends at least 8 hours a day at the Employee's household.

The status of a person as a qualifying individual is determined on a daily basis so a person may only be a qualifying individual for a portion of the Benefit Year if only meeting the foregoing requirements during part of the entire Benefit Year. For example, a child could qualify for the part of the Benefit Year before reaching his or her 13th birthday, but thereafter be ineligible, or a disabled person could live in the Employee's home part of the Benefit Year and then have to go into a nursing home.

The care can be provided by:

- (a) a dependent care center which provides care for more than 6 individuals (other than those who reside at the facility) on a regular basis, complies with applicable governmental laws and regulations for such a facility, and receives a fee, payment, or grant for providing such services;
- (b) an individual who is not (1) the Employee's Spouse or (2) a dependent of the Employee or of the Employee's Spouse, or (3) a child or stepchild of the Employee who is under 19 years of age.

Payment for such care services can be made to the dependent care center, the individual, or an entity providing the individual person or persons performing the services, or to the Employee

to reimburse the Employee for payments to such persons or entities for such services rendered during the Benefit Year subsequent to the Employee becoming a participant under the Plan.

If you experience a short, temporary absence from work of up to 2 consecutive calendar weeks, such as for vacation or minor illness, and your care-giving arrangement requires you to pay for care during the absence, then you may submit claims for reimbursement with respect to days during the absence. If you experience a temporary absence from work that is longer than 2 consecutive calendar weeks, or if your care-giving arrangement does not require you to pay for care during the period of your absence from work, then you will not be eligible for Dependent Care FSA benefits that are allocable to the specific days you are absent from work.

The foregoing provisions will all be interpreted in accordance with the rules under Section 21 of the Tax Code so only payments which would qualify under such Section 21 for a possible dependent care credit will be payable under the Plan.

Claims Process to Obtain Dependent Care FSA Benefits. The service provider must submit a bill for qualifying services to the Claims Administrator along with such provider's taxpayer identification number, or such submission should be made by the Employee if seeking reimbursement for payments made by the Employee to such service provider. Each submission should show that the bill is for qualifying expenses for services provided during the Benefit Year subsequent to the Employee becoming a participant under the Plan, and the Claims Administrator may require appropriate evidence that the requested payment qualifies for payment under the Plan, including that the services were rendered for a qualifying individual.

The benefits payable to you or for your benefit cannot exceed at any time the amount then credited to your account under the Plan on account of your Compensation Reduction Agreement.

The Claims Administrator will notify you in writing of any determination made denying requested benefits and the basis for such decision, and describing any further documentation required to substantiate your right to such benefits. If you believe the Claims Administrator's decision is not correct, you may review any pertinent documentation in the hands of the Employer or the Claims Administrator, and file a written request within 60 days for a review of such decision by the Claims Administrator. In connection with such review, you may make a presentation to the Claims Administrator in writing or in person or through a designated representative in support of your position. The Claims Administrator will give you a written decision on such review within 60 days following such presentation, setting forth the specific Plan provisions on which the decision is based.

If you terminate participation in the Dependent Care FSA portion of the Plan, you will only be entitled to reimbursement of qualifying Dependent Care Expenses incurred prior to termination. However, such Participant may submit claims for employment related Dependent Care expense reimbursements for claims incurred up to the date of termination and submitted within 90 days after termination, based on the level of the Participant's Dependent Care FSA as of the date of termination.

All other claims must be submitted within 90 days after the end of the Benefit Year.

Tax Treatment of Benefits. Your benefits under the Dependent Care FSA are not taxable to the extent they do not exceed your maximum allowable benefits for the Benefit Year. The only exception would be that if the Internal Revenue Service should determine that in fact the expense did not qualify under the requirements of Section 21 of the Internal Revenue Code,

then the payment of such expense by the Employer would not qualify as a tax-free fringe benefit and would be taxable to you.

To the extent that the Dependent Care FSA pays expenses that might otherwise constitute a deductible expense or qualify for a dependent care tax credit on your income tax return, those expenses may not be claimed as a deduction or for a credit, since there is no out-of-pocket expense to you.

Grace Period For Claims. If the benefits paid during the Benefit Year under the Dependent Care FSA are less than the amount of your related Compensation Reduction Agreement, the remaining account balance may be applied to pay qualified dependent care expenses you incur and submit to the Claims Administrator for payment within 2 ½ months after the end of the Benefit Year. This period is known as the grace period. If your Dependent Care FSA account balance is not used up within this grace period, it will no longer be available to pay benefits.

If a qualified dependent care expense is submitted for payment by the end of the grace period, but the Claims Administrator needs additional time to determine if it is payable under the Plan, the subsequent payment thereof is treated as payment by the deadline for payment for a Benefit Year, and the fact that it is actually paid after such deadline does not prevent such payment from being treated as paid out of the allocation for the Benefit Year for which submitted.

Qualified dependent care expenses submitted for payment during the grace period will be reimbursed from the prior Benefit Year account balance before any amounts allocated to the Plan for the current Benefit Year will be applied.

Forfeiture of Unused Amounts. If your qualifying expenses for the Benefit Year and for the grace period are less than the amount of your compensation reduction allocated to the Dependent Care FSA portion of the Plan, the excess credited amount in your bookkeeping account will be forfeited. There is no carry-over of unused benefits to a subsequent Benefit Year, or any restoration to you of the amount of your compensation reduction for which you did not receive a dependent care benefit.

The Claims Administrator will provide you with a statement of your account periodically during the Benefit Year.

Absence Due to FMLA. In the event you are absent from work due to an approved family or medical leave of absence that is covered under the Family and Medical Leave Act of 1993 ("FMLA"), and you return from leave within the same Benefit Year the leave began, your participation in the Dependent Care FSA portion of the Plan will continue with no change in your prior elections, unless you have a qualifying change in status entitling you to make a new election. If you made no contributions to the Dependent Care FSA portion of the Plan during the leave, your credits will be reduced prorata for the period during the FMLA leave. If you return from FMLA leave in a later Benefit Year, you will be required to complete and submit a new election and Compensation Reduction Agreement in order to participate in the Dependent Care FSA portion of the Plan.

Cessation of Participation. Your participation in the Dependent Care FSA portion of the Plan will end as of the earliest of:

- the date your election to participate in the Dependent Care FSA portion of the Plan expires or is terminated;
- the date you cease to be an Employee;

- the date you terminate employment; or
- the on which the Plan terminates.

If you are subsequently reemployed in a position eligible to participate in the Dependent Care FSA portion of the Plan, and elect to participate once again at the time you are rehired, your participation will begin on the date of your election.

Termination of Dependent Care Assistance Benefit. In the event that the Employer goes out of business, or for any other reason terminates the Dependent Care FSA portion of the Plan, you would still be entitled to have the unused amounts credited to your bookkeeping account under the Plan applied to pay your qualified dependent care expenses during the balance of the Benefit Year. If any such termination should also terminate your Compensation Reduction Agreement, your compensation for the balance of the Benefit Year would be adjusted to reflect that the Compensation Reduction Agreement was no longer in effect.

Nondiscrimination Requirements. It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d). The nondiscrimination requirements generally provide that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year may be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer.

If the Plan Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129, the Plan Administrator may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance. Any act taken by the Plan Administrator will be carried out in a uniform and nondiscriminatory manner. If the Plan Administrator decides to reject any elections or reduce contributions or benefits, it will be done in the following manner. First, the salary reduction elections designated for the Dependent Care Flexible Spending Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year will be reduced, until the nondiscrimination tests set forth in this section are satisfied or until the amount designated equals the amount designated by the affected Participant who has elected the second highest contribution to the Dependent Care Flexible Spending Account for the Benefit Year. This process will continue until the nondiscrimination tests are satisfied.

OPT-OUT CASH BENEFITS

Eligible Employees may elect to waive the group Medical and Prescription Drug benefits for which they are eligible under the Plan, and receive instead optional cash payments (Opt-out Cash Benefits) as a supplement to their regular cash compensation. Opt-out Benefits are subject to tax, just like your regular employment compensation, and are payable on a bi-weekly basis.

To elect the Opt-out Cash Benefits, you must provide the Plan Administrator with proof that you have health coverage from another source, in the manner specified by the Plan Administrator. Documentation from the health insurance provider or sponsoring employer may be sufficient, however an identification card alone is not considered valid proof of coverage unless you have Canadian universal health coverage, military Tri-care coverage, or Medicare Parts A and B. Additionally, in order to be eligible for Opt-out Cash Benefits you must complete, sign and file a benefit election form waiving group Medical and Prescription Drug benefits under the Plan. This must generally be done during open enrollment, except that newly eligible Employees must do this prior to the date their Medical coverage under the Plan would otherwise begin. To continue to receive the Opt-out Cash Benefit every year during open enrollment you must make a new Opt-out Cash Benefit election.

The amount of the annual Opt-out Benefit, if any, is set annually, and is payable in equal installments over the course of the year. In the event you are eligible to make a mid-year election change in your Medical coverage, or if you make an Opt-out Cash Benefit election mid-year, the payments will be a pro-rata percentage of the annual benefit amount.

PRE-TAX PREMIUM BENEFITS

When an Eligible Employee elects Medical and Prescription Drug coverage under the Plan, they will automatically be enrolled in the Pre-tax Premium benefit, unless they elect during the open enrollment or other election period not to participate in the Pre-tax Premium benefit. Your election will be equal to the amount of the applicable Employee-portion of the premiums, as provided for under the benefit election form and Compensation Reduction Agreement. In this way, the Employer will automatically contribute on your behalf enough of your compensation to pay your portion of eligible pre-tax premiums for benefits under the Plan.

If an eligible Employee is automatically enrolled in Medical and Prescription Drug coverage under the Plan under the provisions applicable to those portions of the Plan, the Employee will automatically be deemed to have elected the Pre-tax Premium benefit, in the amount of the applicable premiums and will be deemed to have entered into a Compensation Reduction Agreement for those amounts.

When an eligible Employee elects Dependent Care FSA benefits or Health FSA benefits, the Employee's compensation from the Employer will be reduced by the amount he or she elects.

PRE-TAX HSA CONTRIBUTIONS

If an eligible Employee has a Health Savings Account ("HSA") established and maintained outside of this Plan, they can make an election through this Plan to make Pre-Tax HSA Contributions on a salary reduction basis through a Compensation Reduction Agreement. The

Plan will forward the Pre-Tax HSA Contributions to the trustee/custodian that the eligible Employee selects. This election can be changed prospectively at any time during the Plan Year, and your new election will apply as soon as administratively feasible, but generally effective no later than the first day of the next calendar month following the date the election change was filed.

An HSA can generally be used for reimbursement of “qualified eligible medical expenses” as described in Tax Code section 223(d)(2).

You are not eligible to elect Pre-Tax HSA Contributions for any month in which you are covered by the Health FSA benefit under the Plan. This ineligibility regarding HSA contributions extends through the last day of the month following the end of the Health FSA’s grace period, unless your Health FSA account balance at the end of the calendar year prior to the start of the grace period was zero. Note that no contributions can be made to an HSA in any month that you or your Spouse are participating in any general purpose health flexible spending account outside of the Plan.

The Pre-Tax HSA Contribution amount you may elect cannot exceed the statutory maximum amount that applies based on the category of coverage (i.e., single person or family coverage) you elected through the Plan for the High Deductible Health Plan for the year of the contribution. The statutory maximum amounts change periodically (for 2023: \$3,850 for single coverage and \$7,750 for family coverage). Participants age 55 or older may also elect to make catch up Pre-Tax HSA Contributions up to the statutory maximum amount (for 2023: \$1,000).

UDM may elect to make employer contributions to your HSA. In the event UDM elects to make any employer contributions, the contributions will be made available on a uniform basis to all eligible Employees with comparable coverage, and you will be notified in advance of the amounts and the timing. Note that employer contributions reduce the amount you may contribute for the year through Pre-Tax HSA Contributions.

Your HSA is not an employer-sponsored or maintained employee benefit plan. The Pre-Tax HSA Contributions benefit provided under this cafeteria plan consists solely of the ability to make pre-tax salary reduction contributions. Your HSA is not subject to ERISA. The HSA trustee/custodian you select is not subject to the authority or control of UDM, the Plan Administrator. Or the Plan’s Pre-Tax HSA Contribution administrator (currently PayFlex Systems USA, Inc.) UDM reserves the right to limit the trustees/custodians to which the Plan will send Pre-Tax HSA Contributions, in its discretion, for administrative convenience. The Plan’s Pre-Tax HSA Contribution administrator will maintain records to keep track of the Pre-Tax HSA Contributions an eligible Employee makes, but it will not create a separate fund or otherwise segregate assets associated with such contributions. The terms and conditions governing your HSA are described in the HSA trust or custodial agreement provided to you by the applicable trustee/custodian, and are not a part of this Plan.

ARTICLE VIII
PROVISIONS APPLICABLE ONLY TO CERTAIN HEALTH PLAN BENEFITS

The special rules in this section apply to the specified portions of the Health Plan benefits (the Medical and Prescription Drug, Dental, Vision, and Health Flexible Spending Account portions of the Plan).

LIMITS ON COVERAGE

All Health Plan benefits are subject to the enrollment limitation set forth in the Plan. The Plan pays only for Eligible Medical Expenses incurred by a Participant as limited by the Benefit Booklets and the other provisions of the Plan. Eligible Medical Expenses are covered only if the expenses are incurred after the Participant becomes covered and only to the extent that the services or supplies provided are recommended by a Physician and are essential for the necessary care and treatment of any Injury or Illness. Charges in excess of the Usual, Reasonable and Customary Charges, Fees and Expenses will not be considered Eligible Medical Expenses. Charges not specifically referred to in the applicable Benefit Booklet as an Eligible Medical Expense are not covered under the Plan.

Further, utilization review is required for services and treatments to be covered, to the extent provided under the applicable Benefit Booklet.

Even if an expense is an Eligible Medical Expense, it may not be covered by the Plan, or may not be covered in full. In general, any applicable Deductible must be satisfied before any portion of an Eligible Medical Expense will be paid by the Plan. A Deductible is the amount of Eligible Medical Expenses described in the applicable Benefit Booklet that a Participant must incur as a Deductible during a calendar year and while covered under the Plan before benefits are payable. Additionally, after the Deductible has been met, if applicable, the Participant must pay the Co-Payment or Co-Insurance portion of an Eligible Medical Expense, up to any applicable Out-of-Pocket Limit. The percentage of Eligible Medical Expenses not paid by the Plan (because the Co-Insurance percentage payable by the Plan is less than 100%) is the Participant's Co-Insurance percentage. A Co-Payment is a fixed dollar amount that must be paid by the Participant, with the balance to be paid by the Plan. After any applicable Annual Out of Pocket Limit has been reached the Participant does not have to pay any additional Co-Insurance for such coverage for the remainder of the calendar year and the Plan will pay 100% of all additional Eligible Medical Expenses for such coverage for the remainder of the calendar year, subject to limitations set forth in the Benefit Booklets.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (MEDICAL, DENTAL AND VISION BENEFITS ONLY)

You may be eligible to enroll your child for coverage under the Health Plan if required by the terms of a "Qualified Medical Child Support Order." A Qualified Medical Child Support Order ("QMCSO") is a judgment, decree or order (including approval of a settlement agreement) issued by a state court or through an administrative process under state law that creates or recognizes the right of a child to receive benefits under a group health plan. The Plan Administrator determines whether a proposed court order is a QMCSO. Once the Plan Administrator determines that the order meets the requirements for a QMCSO, coverage will be provided in accordance with federal and applicable state law. If the Plan Administrator receives a QMCSO, you and the affected child will be notified by the Plan Administrator before benefits are provided as required by the order. Please contact the Human Resources Department for more information.

Procedure. Except in the case of a National Medical Support Notice as described below, if the Plan shall receive a Medical Child Support Order (as hereinafter defined), the following procedures shall apply:

- The Plan Administrator shall promptly notify the Participant and each Alternate Recipient (as hereinafter defined) of the Plan's receipt of such order, of the Plan's procedures for determining whether a Medical Child Support Order is a Qualified Medical Child Support Order, and of the right of the Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.
- Within a reasonable period after receipt of such order, the Plan Administrator shall determine whether such order is a Qualified Medical Child Support Order and notify the Participant and each Alternate Recipient of such determination. In making such determination, the Plan Administrator may, in its sole discretion, apply to a court of competent jurisdiction for its determination.
- Any determination of the Plan Administrator shall be subject to the applicable Claims, Claims Appeal and External Claims Review Procedures of the Plan.

Effect of Determination. If the Plan Administrator determines that a Medical Child Support Order is a Qualified Medical Child Support Order or a National Medical Support Notice is deemed to be a Qualified Medical Child Support Order as described below, then:

- The Alternate Recipient shall be considered a Dependent Child of the Participant under the medical care provisions of the Plan.
- Any payment for benefits in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian (or the provider, with the approval of the custodial parent or guardian). A payment of benefits to an official of a State or political subdivision thereof whose address has been substituted for the address of the Alternate Recipient, shall be treated as payment of benefits to the Alternate Recipient for purposes hereof.
- The Alternate Recipient shall be considered a Participant of the Plan for purposes of the reporting and disclosure requirements of Part 1 of ERISA.
- Except as provided below, coverage of the Alternate Recipient shall be effective as of the latest of:
 - (1) the first day of the month specified in the Order;
 - (2) the first day of the month following the determination by the Plan Administrator; or
 - (3) the earlier of (A) the first day of the month following the receipt by the Plan of the first premium payment required for coverage, if any, or (B) the effective date of a court or administrative order requiring the Employer to withhold from the Participant's compensation, the Participant's share, if any, of premiums for health coverage and to pay such share of premiums to the Plan.

- If the Plan and any fiduciary under the Plan acts in accordance with the provisions of this section in treating a medical child support order as being (or not being) a Qualified Medical Child Support Order, the Plan's obligation to the Participant and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

Special Eligibility Rules for Qualified Medical Child Support Orders. Solely for purposes of determining if an Order is a Qualified Medical Child Support Order under this Article VII:

- The definition of Dependent Children will not be deemed to exclude from health coverage under the Plan:
 - (1) A Child born out of wedlock;
 - (2) A Child that does not reside with the Participant; or
 - (3) A Child not claimed as a dependent on the Participant's Federal income tax return; but only if a Qualified Medical Child Support Order is in effect for such Child which requires the Participant, the other parent or a State Agency to pay 100% of the cost of health coverage for such child, through withholding from the Participant's compensation or otherwise.
- If any Qualified Medical Child Support Order requires a participant to provide health coverage for an Alternate Recipient:
 - (1) Such Participant may enroll such Alternate Recipient for family coverage pursuant to the procedures of the Plan.
 - (2) If the Participant is enrolled but fails to make application to obtain coverage of such Alternate Recipient, such Alternate Recipient shall be enrolled in family coverage upon application by the Alternate Recipient's other parent or by the State Agency administering the program under Subchapter XIX or Part D of Subchapter IV of Chapter 17 of Title XIX of the Social Security Act (42 U.S.C.A. Section 1396 et seq.)(the "Social Security Act").

Termination of Coverage. Except to the extent required under COBRA, coverage for an Alternate Recipient will terminate:

- When the Qualified Medical Child Support Order is no longer in effect;
- When the Alternate Recipient's age exceeds the maximum age under which a Dependent Child may participate under the Plan;
- When the Employer is provided written evidence that the Alternate Recipient is or will be enrolled in comparable health coverage which will take effect not later than the effective date of such disenrollment; or
- The Employer has eliminated family health coverage for all of its employees.

National Medical Support Notice. If the Plan Administrator receives an appropriately completed National Medical Support Notice promulgated pursuant to section 401(b) of the Child Support Performance and Incentive Act of 1998 (the "Child Support Act") with respect to a Child of a

noncustodial parent, and the Notice meets the requirements below, the Notice will be deemed to be a Qualified Medical Child Support Order in the case of such Child.

In any case in which an appropriately completed National Medical Support Notice is issued with respect to a Child of a Participant who is such Child's noncustodial parent, and the Notice is deemed to be a Qualified Medical Child Support Order, the Plan Administrator, within 40 business days after the date of the Notice, shall:

- Notify the State agency issuing the Notice with respect to such Child whether coverage of the Child is available under the terms of the Plan and, if so, whether such Child is covered under the Plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the official of a State or political subdivision thereof substituted for the name of such Child) to effectuate the coverage; and
- Provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

Nothing in this section shall be construed as requiring the Plan, upon receipt of a National Medical Support Notice, to provide benefits under the Plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as of immediately before receipt of such notice.

A noncustodial parent shall be liable to the Plan for employee contributions required under the Plan for enrollment of the Child, unless such noncustodial parent properly contests such enforcement based on a mistake of fact.

Definitions. For purposes of this section, the following definitions apply:

- "Alternate Recipient" means any Child of an Employee who is recognized under a medical child support order as having a right to enrollment under the Plan with respect to such Employee.
- "Child" includes any child adopted by or placed for adoption with the Participant.
- "Medical Child Support Order" means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or an authorized government agency which:
 - (1) provides for child support with respect to a Child of a Participant under the Plan or provides for health benefit coverage to such a Child, is made pursuant to a state domestic relations law (including community property law), and relates to group health benefits under the Plan, or
 - (2) enforces a law relating to medical child support described in Section 1908 of Title XIX of the Social Security Act with respect to the group health benefit under the Plan.
- "Qualified Medical Child Support Order" means a Medical Child Support Order which:
 - (1) creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive health benefits for which a Participant or Beneficiary is eligible under the group health provisions of the Plan, and

(2) meets the following requirements:

- clearly specifies the name and last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the order;
- clearly specifies a reasonable description of the type of coverage to be provided by the Plan to each such Alternate Recipient, or the manner in which such type of coverage is to be determined;
- clearly specifies the period to which such order applies;
- clearly specifies each plan to which such order applies; and
- does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of Title XIX of the Social Security Act.

**SPECIAL ENROLLMENT (MEDICAL, PRESCRIPTION
DRUG, DENTAL, AND VISION BENEFITS ONLY)**

If you or a Dependent are eligible to enroll for coverage in the Medical, Prescription Drug, Dental, or Vision portions of the Plan but you have not yet done so, you may enroll if:

1. You or your Dependent had coverage under a group health plan or had health insurance coverage when you became eligible for the Plan; and

You stated in writing that you declined coverage under the Plan because you had coverage under a group health plan or other health insurance coverage at the time you became eligible and provided proof of that coverage, as required by the Employer; and

the previous coverage that you or your Dependent had was one of the following:

- COBRA coverage that was exhausted;
- Terminated coverage because you were no longer eligible for certain reasons, including legal separation, divorce, death, or termination from employment;
- Terminated coverage because the employer's contributions ended; or
- State Children's Health Insurance Program ("SCHIP") or Medicaid coverage that terminated because the individual was no longer eligible.

If your previous coverage ended for one of the above reasons, to be eligible for Special Enrollment in the Plan, you or your dependent must request enrollment not more than 30 days after your previous coverage ended.

2. If you are enrolled in or are eligible for coverage under the Plan and you get married, have or adopt a child, or a child is placed for adoption with you, you and the new Dependent may receive coverage under the Plan effective on the date of the marriage,

birth, adoption or placement for adoption if coverage is requested within 30 days from that date.

Additionally, if you or your Dependent are enrolled in the Plan and subsequently become eligible for SCHIP or Medicaid coverage (including under any waiver or demonstration project conducted under or in relation to those plans), then you may change your elections under the Plan if you submit a request within 60 days from the date you or your Dependent are determined eligible.

**MATERNITY AND NEWBORN CHILD COVERAGE
(MEDICAL BENEFITS ONLY)**

Please note that under federal law approval is not required for a hospital stay for a mother or her newborn child in connection with the birth of the child if the hospital stay is not in excess of 48 hours following a normal vaginal delivery or 96 hours following a cesarean section. Under federal law, the Plan may not require a provider to obtain authorization from the Plan for prescribing a hospital stay of 48 hours or less (or 96 hours as applicable). Alternatively, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

**RECONSTRUCTIVE SURGERY FOLLOWING A
MASTECTOMY (MEDICAL BENEFITS ONLY)**

The medical portion of the Plan provides benefits if breast reconstruction is elected in connection with a mastectomy. You will be able to receive coverage under the terms of the Plan for the following:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Protheses and treatment of physical complications resulting from a mastectomy, including lymphedemas.

**MENTAL HEALTH PARITY
(MEDICAL AND PRESCRIPTION DRUG BENEFITS ONLY)**

The Medical and Prescription Drug portion of the Plan providing mental health and substance abuse benefits will not generally have treatment limitations (including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment), financial requirements (including co-pays, co-insurance, out-of-pocket expenses, and deductibles, other than lifetime benefit caps), or out-of-network coverage limitations that differ from those predominantly applicable to medical and surgical benefits under

the Plan. Upon request you will be provided with the criteria used in making a determination regarding whether mental health and substance-related disorder benefits are medically necessary within the meaning of the Plan's coverage provisions. If the application of these mental health parity provisions results in a 2% increase in the actual total costs of coverage in the first year or a 1% increase in any subsequent year with respect to Medical and Prescription Drug (including surgical benefits) and mental health and substance use disorder benefits under the Plan (as determined and certified by an actuary) these provisions will not apply to the Plan or coverage during the following Plan Year.

**GENETIC INFORMATION NONDISCRIMINATION ACT
(APPLIES TO ALL HEALTH PLAN BENEFITS)**

The Genetic Information Nondiscrimination Act ("GINA") prohibits the Plan from improperly discriminating on the basis of genetic information. Genetic information includes the results from genetic testing of a participant or family members, or information regarding the manifestation of a disease or disorder in participants or members of their families (family history). Genetic information cannot be used as a basis for raising premiums or co-pays.

**COBRA CONTINUATION COVERAGE
(APPLIES TO ALL HEALTH PLAN BENEFITS)**

General Rules

In certain circumstances, a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires the Employer to offer you, and your covered Spouse and Dependents, the opportunity to temporarily extend coverage under group health care plans when coverage otherwise would end.³

COBRA continuation coverage is provided by the Employer for the Health Plan to comply with the requirements of federal law. Because the COBRA law only imposes minimum continuation coverage requirements, the Employer's COBRA policies provide and should be interpreted as providing only the minimum rights required by law.

COBRA continuation coverage is a continuation of Health Plan coverage when coverage would otherwise end because of an event known as a "qualifying event." The specific qualifying events for COBRA purposes are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and your Dependents could become qualified beneficiaries if coverage under the Health Plan is lost because of the qualifying event. Under the Health Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

³ See temporary provisions in Claims During Outbreak Period section.

Qualifying Events For Employees

If you are an Employee, you become a qualified beneficiary if you lose your coverage under the Health Plan because either of the following qualifying events occurs:

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

Qualifying Events for Covered Spouses

If you are the Spouse of an Employee, you become a qualified beneficiary if you lose your coverage under the Health Plan because any of the following qualifying events occurs:

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

Qualifying Events for Covered Dependents

Your Dependent child becomes a qualified beneficiary if the child loses coverage under the Health Plan because any of the following qualifying events occurs:

- The Employee dies;
- The Employee's hours of employment are reduced;
- The Employee's employment ends for any reason other than his or her gross misconduct;
- The Employee becomes entitled to Medicare benefits (Part A or Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a Dependent.

Notwithstanding anything stated elsewhere in this Section, a Legally Domiciled Adult/Domestic Partner is not entitled to separately elect COBRA continuation coverage. Continuation coverage will only be provided if the Employee/Retiree elects COBRA continuation coverage, and coverage for such individual will end when the Employee's COBRA coverage ends. The Employee's qualification for Medicare or the death of the Employee will not be a second qualifying event for the Legally Domiciled Adult/Domestic Partner.

Notice of COBRA "Qualifying Event"

The Health Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

The Employer is required to notify the Plan Administrator of the following qualifying events:

- The reduction of the Employee's hours of employment;
- The termination of the Employee's employment for any reason other the Employee's gross misconduct;
- The death of the Employee; and
- The Employee's becoming entitled to benefits under Medicare Part A or Part B or both.

The Employer must notify the Plan Administrator of the qualifying event within 30 days of the later of the date the qualifying event occurs or the date any qualified beneficiary loses coverage because of the qualifying event.

Under the law, the **covered Employee, covered Spouse and covered Dependents have the responsibility to inform the Plan Administrator in writing** of a divorce, legal separation, or a Dependent child losing Dependent status under the Health Plan. The Plan Administrator must be notified within 60 days of the later of the date any of these “qualifying events” occurs, or the date coverage would be lost because of the qualifying event. A copy of the divorce or legal separation court order or documentation supporting the child’s loss of Dependent status, as applicable, must be included with the notice. **This notice must be postmarked or hand delivered to the Plan Administrator by the end of the 60-day period.**

Electing COBRA

Once the Plan Administrator receives notice that a qualifying event has occurred, the Plan Administrator will offer COBRA continuation coverage to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. A covered Employee who is a qualified beneficiary may elect COBRA continuation coverage on behalf of their Spouse who is a qualified beneficiary. A parent who is a qualified beneficiary may elect COBRA continuation coverage on behalf of Dependents who are qualified beneficiaries.

A qualified beneficiary must elect COBRA coverage within 60 days after the later of:

- The date of the election notice provided by the Plan Administrator; or
- The date the qualified beneficiary lost coverage because of the qualifying event.

For each qualified beneficiary who timely elects COBRA continuation coverage, COBRA continuation coverage will begin as of the later of:

- The date of the qualifying event; or
- The date Health Plan coverage would otherwise have ended because of the qualifying event.

If you do not timely elect COBRA continuation coverage, your coverage under the Health Plan will end.

The period during which any Covered Employee or Covered Dependent is covered pursuant to the Plan’s provisions regarding USERRA Coverage or FMLA Coverage shall be considered COBRA coverage for up to the maximum period required under COBRA. After the time period provided under the Plan’s provisions regarding USERRA Coverage or FMLA Coverage, if the Covered Employee or Covered Dependent terminates coverage after the maximum period required under COBRA, his COBRA period shall be considered exhausted and no COBRA Continuation Coverage will be offered. If, however, the Covered Employee or Covered Dependent terminates coverage under Plan’s provisions regarding USERRA Coverage or FMLA Coverage prior to the maximum period required under COBRA, COBRA coverage will be offered at UDM COBRA rates for the duration of the maximum period required under COBRA.

If a Covered Employee or Covered Dependent is entitled to extended coverage under the Retiree Coverage provisions of this Plan and also under COBRA, then the Covered Employee or Dependent must elect whether to extend coverage as Retiree coverage or as COBRA coverage. Any Covered Employee or Covered Dependent who elects extended coverage under the Retiree Coverage provisions of the Plan in lieu of receiving COBRA coverage will be deemed to waive all

of his COBRA rights, except as otherwise provided the Retiree Coverage provisions of the Plan with respect to a subsequent Qualifying Event of a Dependent.

If a Covered Dependent is entitled to extend coverage under the Survivor Coverage portion of the Plan, then the Covered Dependent must elect whether to extend his coverage as coverage of a Dependent of a deceased Employee or as COBRA coverage. Any Covered Dependent of a deceased Employee who elects extended coverage under the Survivor Coverage portion of the Plan in lieu of receiving COBRA coverage will be deemed to waive all of his COBRA rights, except as otherwise provided in the Survivor Coverage portion of the Plan with respect to a Dependent of a deceased Employee for whom the COBRA election period has not then expired.

If a Covered Dependent is entitled to extend coverage under the Survivor Coverage portion of the Plan upon the death of a Retiree and in lieu of electing COBRA coverage the Retiree previously elected to extend coverage for such Covered Dependent under Retiree Coverage portion of the Plan, such Covered Dependent will not have any right to elect COBRA coverage.

Paying for COBRA

By the 45th day following the date you make your election, you are required to make your first premium payment to the Employer for your coverage. For all subsequent premium payments, you will have a 30-day grace period from the due date in which to make your payment.

If you do not make your first premium payment or any subsequent premium payments on time, your COBRA coverage will end and cannot be reinstated.

If timely payment is made in an amount that is not significantly less than the amount required to be paid by the Plan for such coverage, then the amount paid shall be deemed to satisfy the contribution requirement, unless the Plan notifies the Employee or Dependent of the amount of the deficiency and grants the Employee or Dependent at least 30 days from the date the notice is provided to pay the deficiency.

A COBRA premium payment will be considered to be made on the date it is sent to the Plan.

In the event of a failure to make timely payment, termination of coverage shall be retroactive to the first day of the first period for which payment was not made.

Scope of Coverage Continued

If you choose COBRA continuation coverage, the Employer is required to give you coverage which, as of the time coverage is being provided, is the same as that provided under the Health Plan to similarly situated Employees, Spouses or Dependents. If this coverage has been or is later discontinued or changed, your coverage will also be discontinued or changed. However, you must be allowed to elect coverage under any other plan maintained by the Employer that is available to similarly situated Employees, Spouses or Dependents.

You are allowed to change your COBRA continuation coverage to add your child born or placed with you for adoption during the COBRA continuation coverage period. Any such change must be made under the same terms and conditions for adding newborn or newly adopted children applicable to similarly situated active Employees. If you are a covered Employee, your newborn or newly adopted child added to your COBRA continuation coverage will be entitled to his or her own COBRA continuation coverage if a second qualifying event occurs.

You may add a Legally Domiciled Adult/Domestic Partner to your COBRA coverage in the same way you may add a child born or placed with you for adoption during the COBRA continuation coverage period.

Health Flexible Spending Accounts

If you participate in the Health FSA portion of the Plan, see the subsection of this Plan governing the Health FSA entitled "COBRA Continuation Rights," which describes special COBRA rules that apply to Health FSAs.

Length of Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage can last for up to 36 months after any of the following qualifying events:

- The death of the Employee;
- The Employee's becoming entitled to benefits under Medicare Part A or Part B or both;
- The divorce or legal separation of the Employee and Spouse; or
- A Dependent child's loss of eligibility for coverage under the Health Plan as a Dependent.

COBRA continuation coverage generally lasts for only 18 months after either of the following qualifying events:

- The reduction in the Employee's hours of employment; or
- The termination of the Employee's employment for any reason other than the Employee's gross misconduct.

However, there are three ways in which this 18-month period of COBRA continuation coverage can be extended.

1. Extension of Coverage Period if Employee is Entitled to Medicare Before Qualifying Event

If the Employee became entitled to benefits under Medicare Part A or Part B or both less than 18 months before the Employee's hours of employment were reduced or the Employee's employment was terminated other than because of the Employee's gross misconduct, COBRA continuation coverage for qualified beneficiaries ***other than the Employee*** can last for up to 36 months after the date the Employee became entitled to Medicare benefits.

For example, if a covered Employee became entitled to Medicare 8 months before the Employee's employment terminated, COBRA continuation coverage for the Employee's Spouse and Dependents can last up to 36 months after the date the Employee became entitled to Medicare benefits. The Spouse and Dependents will be eligible for COBRA continuation coverage for 28 months after the date of Employee's termination (36 months minus 8 months). However, the Employee will only be eligible for COBRA continuation coverage for 18 months after the date of the Employee's termination.

2. *Extension of Coverage Period Based on Disability*

If any qualified beneficiary in your family is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to up to an additional 11 months of COBRA continuation coverage, for a maximum COBRA continuation coverage period of 29 months.

To be eligible for additional coverage:

- The Social Security Administration must determine that the disability started before the 60th day of the COBRA continuation coverage;
- The disability must last until the end of the initial 18-month period of COBRA coverage; and
- The Plan Administrator must be notified in writing within 60 days of the date of the Social Security Administration's determination and before the end of the initial 18-month period of COBRA continuation coverage.

A copy of the Social Security Administration's determination must be included with the written notice sent to the Plan Administrator.

3. *Extension of Coverage After Second Qualifying Event*

If another qualifying event occurs while qualified beneficiaries are receiving COBRA continuation coverage during an 18-month period of coverage, qualified beneficiaries who are a Spouse or a Dependent will be eligible for up to an additional 18 months of COBRA continuation coverage, for a maximum of 36 months from the date of the original qualifying event.

This extension is available if one of the following qualifying events occurs while a qualified beneficiary who is a Spouse or Dependent has received less than 18 months of COBRA continuation coverage after the Employee's reduction in hours or termination of employment and the event would have been a qualifying event if the reduction in hours or termination of employment had not occurred:

- The Employee or former Employee dies;
- The Employee or former Employee becomes entitled to benefits under Medicare Part A or Part B or both;
- The Employee or former Employee and Spouse are divorced or legally separated; or
- A Dependent child loses eligibility for coverage under the Health Plan as a Dependent.

In all of these cases, you must notify the Plan Administrator in writing of the second qualifying event within 60 days of the later of the date the second qualifying event occurred or the date coverage is lost because of the qualifying event. You must provide supporting documentation with the written notice (for example, a final judgment of divorce or the child's birth certificate). This notice must be postmarked or hand delivered to the Plan Administrator by the end of the 60-day period.

If you do not notify the Plan Administrator of the second qualifying event by the end of the 60-day period, affected qualified beneficiaries will not be eligible for the 18-month extension of COBRA continuation coverage.

The following chart briefly summarizes the qualifying events and the maximum period of COBRA continuation coverage described above:

QUALIFYING EVENT	QUALIFIED BENEFICIARIES	
If coverage stops because ...	Employees may continue coverage for a maximum of ...	Each covered Spouse and Dependent may continue coverage for a maximum of ...
You stop working for the Employer (for reasons other than gross misconduct)	18 months	18 months
Your hours of employment are reduced below Plan requirements	18 months	18 months
You die	N/A	36 months
You and your Spouse divorce or legally separate	N/A	36 months
Your child loses Dependent status	N/A	36 months (child only)
You become entitled to Medicare	N/A	36 months

Termination of COBRA Coverage

Your COBRA continuation coverage period will be cut short if:

- the Employer stops providing plan benefits to any Employees, Spouses and Dependents (including successor plans);
- the premium required for your COBRA continuation coverage is not paid on a timely basis;
- you first become covered after the date a COBRA election is made (as an Employee or otherwise) under another employer's group health plan that does not include a pre-existing condition limitation or exclusion with respect to any pre-existing condition you may have at that time. However, your COBRA continuation coverage can be terminated if you become covered (as an Employee or otherwise) under another group health plan if any pre-existing condition limitation or exclusion in that plan does not apply to you because of restrictions on the application of pre-existing condition limitations and exclusions enacted in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"); or
- you first become entitled to Medicare after the date a COBRA election is made.

Cost of COBRA

Under the law, you will be required to pay the cost of COBRA continuation coverage, which can be up to 102% of the full cost of coverage. If you qualify for extended benefits because of disability, and elect the additional 11 months of coverage, you will be required to pay up to 150% of the full cost of coverage for the additional period.

Your COBRA coverage is provided subject to your eligibility. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

If You Have Questions

Questions concerning the Health Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator.

For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Health Plan Informed of Changes

In order to protect your family's rights, you must keep the Plan Administrator informed of any changes in the addresses or marital status of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Please see the General COBRA Notice that is attached to this Plan.

AFFORDABLE CARE ACT (APPLIES TO MEDICAL AND PRESCRIPTION DRUG BENEFITS)

The Plan will comply with the following provisions of the Patient Protection and Affordable Care Act ("PPACA"), to the extent required by law.

No Lifetime Limits on Essential Health Benefits

The Plan may not impose a lifetime limit on the dollar value of certain group health benefits. Unless the Employer elects to extend this prohibition to all group health benefits available under the Plan, this prohibition is limited to the "essential health benefits" provided by the Plan. The Employer is not prevented from excluding all benefits under the Plan for a condition, subject to other requirements of Federal or State law.

"Essential health benefits" generally include benefits provided by the Plan under the following categories:

- Prescription drugs;
- Hospitalization;
- Mental health and substance abuse disorder services;
- Chronic disease management;
- Ambulatory patient services;
- Emergency services;
- Maternity and newborn care;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services; and
- Pediatric services.

You will be notified in advance if the Employer extends this prohibition to the non-essential health benefits available under the Plan.

No Pre-Existing Condition Exclusions

The Plan may not impose “pre-existing condition exclusions” with respect to any enrollee (or applicant for enrollment). A “pre-existing condition exclusion” is a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under the Plan, regardless of whether any medical advice, diagnosis, care, or treatment was recommended or received before that day. A “pre-existing condition exclusion” also includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual’s health status before the individual’s effective date of coverage (or, if coverage is denied, the date of the denial) under the Plan.

No Rescission of Coverage

The Plan may not rescind coverage under the Plan, policy, certificate, or contract of insurance, with respect to an individual (including a group to which the individual belongs, or family coverage in which the individual is included) once the individual is covered under the Plan.

This prohibition on the “rescission of coverage” does not apply if:

- The individual (or a person seeking coverage on behalf of that individual) performs an act, practice, or omission that constitutes fraud; or
- The individual makes an intentional misrepresentation of material fact.

The Plan must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded, regardless of whether the coverage is insured or self-insured, or whether the coverage applies to an entire group or only to an individual within the group.

A “rescission of coverage” is a cancellation or discontinuance of coverage that has retroactive effective, but does not include a cancellation or discontinuation of coverage if:

- The cancellation or discontinuation of coverage has only prospective effect; or
- The cancellation or discontinuation of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Required Coverage of Preventive Health Services

In the event that the Plan or a portion of the Plan Medical and Prescription Drug coverage loses its status as a “Grandfathered” plan in the future, then the non-Grandfathered portion of the Plan must provide coverage for the following preventive items and services:

- Evidence-based items and services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved, excluding breast cancer screening, mammography, and prevention services that were recommended in or around November 2009;

- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- Evidence-informed preventive care and screenings for infants, children and adolescents provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- Evidence-informed preventive care and screenings for women, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The rules of this section do not prevent the Plan from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an above-listed preventive item or service to the extent not specified in the recommendation or guideline. In addition, the rules of this section do not require the Plan to provide the above-listed preventive items or services if the preventive item or service is delivered by an out-of-network provider.

The Plan may not impose any cost-sharing requirements (such as a co-payment, co-insurance, or deductible) on the above-listed preventive items or services. In the case of an office visit:

- If the preventive item or service is billed separately (or is tracked as individual encounter data separately) from an office visit, then the Plan may impose cost-sharing requirements with respect to the office visit;
- If the preventive item or service is not billed separately (or is not tracked as individual encounter data separately) from an office visit, and the primary purpose of the office visit is the delivery of the preventive item or service, then the Plan may not impose cost-sharing requirements with respect to the office visit; and
- If the preventive item or service is not billed separately (or is not tracked as individual encounter data separately) from an office visit, and the primary purpose of the office visit is not the delivery of the preventive item or service, then the Plan may impose cost-sharing requirements with respect to the office visit.

If the Plan has a network of providers, the rules of this section do not prevent the Plan from imposing cost-sharing requirements for preventive items or services that are delivered by an out-of-network provider.

This section is effective for Plan Years beginning on or after the date that is one year after the date the recommendation or guidance is issued. Nothing in this section requires the Plan to provide continued coverage for any preventive items and services that are no longer subject to a recommendation or guideline.

Participant Choice of Health Care Professionals

If the Plan requires or provides for designation by you or your Dependents of a participating primary care provider, then you may designate any participating primary care provider who is available to accept you or your Dependents.

Right to Designate Pediatrician as Primary Care Provider of Dependent Child

If the Plan requires or provides for the designation by you or your Dependents of a participating primary care provider for a Dependent child, then you or your Dependents may designate any physician (allopathic or osteopathic) who specializes in pediatrics as the Dependent child's primary care provider if the provider participates in the applicable network **and** the provider is available to accept the Dependent child. Nothing in this section is to be construed to waive any exclusions of coverage under the terms and conditions of the Plan with respect to the coverage of pediatric care.

Patient Access to Obstetrical and Gynecological Care

If the Plan provides coverage for obstetrical or gynecological care and requires the designation by you or your Dependent of a participating primary care provider, then the Plan will not require authorization or referral by the Plan, insurance issuer, or any person (including a primary care provider) in the case of a female participant or Dependent who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. The Plan may require that the professional agree to otherwise adhere to the Plan's or insurance issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the Plan or issuer.

In addition, if the Plan provides coverage for obstetrical or gynecological care and requires the designation by you or your Dependent of a participating primary care provider, then the Plan will treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services by a participating health care professional who specializes in obstetrics or gynecology, as the authorization of the primary care provider.

Nothing in this section is to be construed to either waive any exclusions of coverage under the terms and conditions of the Plan with respect to coverage of obstetrical or gynecological care, or to preclude the Plan from requiring that the obstetrical or gynecological provider notify the primary care health care profession or the Plan of treatment decisions.

Emergency Services

If the Plan provides any benefits with respect to services in an emergency department of a hospital, the Plan will cover emergency services in accordance with the rules of this section.

The Plan will provide coverage for emergency services:

- Without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis;
- Without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services;
- If the emergency services are provided out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers;
- Without regard to any other term or condition of the coverage, other than the exclusion of or coordination of benefits, an affiliation or waiting period permitted by Federal law, or applicable cost-sharing; and

- By complying with certain cost-sharing rules if the emergency services are provided out-of-network. In general, any co-payment amount or co-insurance rate for out-of-network emergency services cannot exceed the cost-sharing requirement for in-network emergency services. However, you may be required to pay the excess of the amount the out-of-network provider charges over the amount the Plan is required to pay in the event the Plan provides benefits with respect to emergency services in an amount equal to the greatest mandated by Federal law. The Plan may impose any cost-sharing requirement other than a co-payment or co-insurance requirement with respect to out-of-network emergency services if the cost-sharing requirement generally applies to out-of-network benefits.

**HIPAA PROVISIONS
(APPLIES TO ALL HEALTH PLAN BENEFITS)**

The Health Information Portability and Accountability Act of 1996, as subsequently amended (“HIPAA”), requires that the Plan include certain provisions in Plan documents and comply with rules to ensure the privacy and security of certain health information.

Definitions

Whenever used in this section of the Plan, the following definitions apply.

Authorized Employee: Any employee or class of employees identified in the Plan Sponsor’s HIPAA Policies and Procedures. **The list of Authorized Employees identified in the Plan Sponsor’s HIPAA Policies and Procedures is incorporated into this Plan by reference.** This list currently includes every class of employees of the Plan Sponsor who may receive PHI relating to Treatment, Payment, Health Care Operations, or other matters pertaining to the Plan in the ordinary course of business. Any employee or person under the control of the Plan Sponsor who receives PHI relating to Treatment, Payment, Health Care Operations, or other matters pertaining to the Plan in the ordinary course of business will also be included and treated as an Authorized Employee, such as an employee, temporary employee, or contract personnel whose duties make it likely that he or she will access, receive, record, or transmit PHI on behalf of the Plan but whose job duties do not require him or her to have access to PHI for purposes of performing administration duties for the Plan. These individuals may consist of, among other persons, an Authorized Employee’s supervisor, secretary, administrative assistant, receptionist, file clerk, a person who has general access to the computer network, an Authorized Employee’s e-mail or who receives an incoming call from a Covered Individual who discusses his or her PHI. Authorized Employees include, but are not limited to: In-house attorneys, Human Resource Managers, Assistant Human Resource Managers, UDM Benefits Staff, and Benefit Representatives.

Business Associate: Any outside vendor who performs a function or activity on behalf the Plan which involves the creation, use or disclosure of PHI.

Health Care Operations:, Plan Administrative Functions, business management, customer service, enrollment, care management, case management, audit functions, fraud and abuse detection, due diligence, and quality assurance. For example, the Plan may review PHI to respond

to an appeal from a denial of benefits or to audit the accuracy of a health care carrier's claims processing and other functions.

Limited Data Set: PHI that excludes the following direct identifiers of an Individual or of relatives, employers, or household members of an Individual: (i) names; (ii) postal address information, other than town or city, State, and zip code; (iii) telephone numbers; (iv) fax numbers; (v) electronic mail addresses; (vi) social security numbers; (vii) medical record numbers; (viii) health plan beneficiary numbers; (ix) account numbers; (x) certificate/license numbers; (xi) vehicle identifiers and serial numbers, including license plate numbers; (x) device identifiers and serial numbers; (xi) Web Universal Resource Locators (URLs); (xii) Internet Protocol (IP) address numbers; (xiii) biometric identifiers, including finger and voice prints; and (ix) full face photographic images and any comparable images.

Minimum Necessary: The use and disclosure of PHI, to the extent practicable, of the Limited Data Set, or, if needed, to the minimum PHI necessary to accomplish the intended purpose of the disclosure, pending further guidance from the Secretary of Health and Human Services ("HHS")

Notice of Privacy Practices: A notice explaining the uses and disclosures of PHI that may be made by the Plan, the Individuals' rights under the Plan with respect to PHI, and the Plan's legal duties with respect to PHI.

Payment: Determining eligibility, processing claims, making pre-certification or pre-authorization decisions, medical review, utilization review, billing, coordinating benefits, and exercising the Plan's' subrogation rights. For example, PHI may be used to pay a doctor's bill for covered services or to reimburse an individual from his or her health care spending account and other functions.

Plan Administration Functions: The administration functions and Health Care Operations performed by the Plan Sponsor on behalf of the Plan. Administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit plan of the Plan Sponsor.

Plan Sponsor: University of Detroit Mercy.

Protected Health Information ("PHI"): Information about an Individual covered under the Plan (whether oral or recorded in any form or medium) that:

- is created or received by the Plan or the Plan Sponsor;
- relates to the past, present or future physical or mental health or condition of the Individual, the provision of health care to the Individual, or the past, present or future payment for the provision of health care to the Individual; and
- identifies the Individual or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual.

Summary Health Information: Information summarizing the claims history, claims expenses, or types of claims experienced by an Individual covered under the Plan, and from which the following information has been removed:

- names;
- any geographic information which is more specific than a five digit zip code;

- all elements of dates relating to an Individual (e.g., birth date) or any medical treatment (e.g., admission date) except the year; all ages for an Individual if the Individual is over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);
- other identifying numbers, such as, Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;
- facial photographs or biometric identifiers (e.g., finger prints); and
- any other unique identifying number, characteristic, or code.

Any other term defined by HIPAA, but not otherwise defined in the HIPAA portion of the Plan will have the same meaning as in HIPAA. Any inconsistency in the definition of a term will be resolved in favor of a meaning that permits the Plan to comply with HIPAA.

HIPAA Privacy Compliance. Neither the Plan Sponsor nor the Plan will use or disclose PHI protected by HIPAA, except as provided by HIPAA or other state or federal law. Further, the Plan Sponsor will ensure that any use or disclosure of PHI is the Minimum Necessary. The Plan will provide Individuals with a Notice of Privacy Practices and will create and maintain HIPAA Policies and Procedures that comply with HIPAA.

Permitted Use or Disclosure of PHI by Plan Sponsor. Any disclosure to and use by the Plan Sponsor of any PHI will be subject to and consistent with the provisions of this section.

The Plan and any health insurance issuer, HMO, or Business Associate, subcontractor or agent servicing the Plan, directly or indirectly, may disclose PHI to the Plan Sponsor to permit the Plan Sponsor to carry out Plan Administration Functions, including but not limited to the following purposes:

- to provide and conduct Plan Administrative Functions related to Payment and Health Care Operations for and on behalf of the Plan;
- for auditing claims payments made by the Plan;
- to request proposals for services to be provided to or on behalf of the Plan; and
- to investigate fraud or other unlawful acts related to the Plan and committed or reasonably suspected of having been committed by a Plan participant.

The uses described above are permissible only if the Notice of Privacy Practices distributed to Individuals in accordance with the Privacy Rule states that PHI may be disclosed to the Plan Sponsor.

The Plan or a health insurance issuer or HMO may disclose to the Plan Sponsor information regarding whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

Restrictions on Plan Sponsor's Use and Disclosure of PHI. The following restrictions apply to the Plan Sponsor's use and disclosure of PHI.

- The Plan Sponsor will not use or further disclose PHI, except as permitted or required by the Plan or as required by law.
- The Plan Sponsor will ensure that any Business Associate, subcontractor or agent, to whom it provides PHI, directly or indirectly, agrees to the restrictions and conditions of this section.

- The Plan Sponsor will not, and will not permit a health insurance issuer or HMO to, use or disclose PHI for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.
- The Plan Sponsor will make an Individual's PHI available to the Individual in accordance with the Privacy Rule.
- The Plan Sponsor will make PHI available for amendment and will, upon notice, amend PHI in accordance with the Privacy Rule.
- The Plan Sponsor will track certain PHI disclosures it makes so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with the Privacy Rule.
- The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of PHI received from the Plan to the Secretary HHS to determine the Plan's compliance with the Privacy Rule.
- The Plan Sponsor will, if feasible, return or destroy all PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control) received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Individual who is the subject of the PHI, when that PHI is no longer needed for the Plan Administration Functions for which the disclosure was made. If it is not feasible to return or destroy all such PHI, the Plan Sponsor will limit the use or disclosure of any PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.
- When using or disclosing PHI or when requesting PHI from another party, the Plan Sponsor must limit PHI to the Minimum Necessary to accomplish the intended purpose of the use or disclosure, and limit any request for PHI to the Minimum Necessary to satisfy the purpose of the request.

Adequate Separation between the Plan Sponsor and the Plan. Only Authorized Employees may be given access to PHI received from the Plan or a health insurance issuer, HMO, or Business Associate servicing the Plan, as outlined in the Plan Sponsor's HIPAA Policies and Procedures. The Authorized Employees identified above will have access to PHI only to perform the Plan Administration Functions which the Plan Sponsor provides for the Plan. The Plan Sponsor will promptly report to the Plan any use or disclosure of PHI in breach, violation of, or noncompliance with, the provisions of this section of the Plan, as required under this section, and will cooperate with the Plan to correct the breach, violation or noncompliance, will impose appropriate disciplinary action or sanctions, including termination of employment, on each employee who is responsible for the breach, violation or noncompliance, and will mitigate any deleterious effect of the breach, violation or noncompliance on any Individual covered under the Plan, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance. Regardless of whether a person is disciplined or terminated pursuant to this section, the Plan reserves the right to direct that the Plan Sponsor, and upon receipt of such direction the Plan Sponsor will, modify or revoke any person's access to or use of PHI.

Purpose of Disclosure of Summary Health Information to Plan Sponsor. The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan. The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the

Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

HIPAA Security Compliance. HIPAA requires that the Plan include certain provisions in Plan documents to ensure the security of electronic PHI in accordance with the Security Rule. This section of the Plan is intended to ensure the Plan's compliance with the Security Rule by placing the required restrictions on the use and disclosure of electronic PHI. The Plan will create and maintain HIPAA Policies and Procedures that comply with HIPAA.

The Plan Sponsor will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that the adequate separation required by the HIPAA Security Rule is supported by reasonable and appropriate security measures;
- Ensure that any Business Associate, subcontractor or agent, to whom it provides this electronic PHI, directly or indirectly, agrees to implement reasonable and appropriate security measures to protect the PHI; and
- Report to the Plan any security incident of which it becomes aware.

Plan Sponsor Certification. The Plan Sponsor will provide (and has provided) the Plan with a certification stating that the Plan has been amended to incorporate the terms of this section and that the Plan Sponsor agrees to abide by the terms of this section. The Plan Sponsor will also provide the Certification upon request to its health insurance issuers, HMOs and Business Associates of the Plan.

Limitation on Reliance. Notwithstanding anything stated elsewhere in this section, the inclusion of this section in the Plan is solely intended to comply with the requirements of HIPAA, HITECH and the Privacy Regulations under HIPAA. The rights of any person under this section are limited to those provided under HIPAA, HITECH and the Privacy Regulations, to the extent such Regulations are valid Regulations under HIPAA and HITECH. No person or entity will acquire any other rights or causes of action under this section.

WELLNESS PROGRAM

The Plan's benefits include a voluntary Wellness Program. The specific benefits provided through the Wellness Program may vary from year to year. See the Benefit Booklet describing the Wellness Benefits for a complete list of available benefits. You will be notified of these benefits in advance, and such notices to be considered part of this Plan. Only the Health Assessment Tool and benefits providing professionally-staffed medical advice are considered medical benefits under this Plan.

Note that the identity of individuals who use the online Health Assessment Tool Risk or professionally-staffed medical advice, and their responses/subjects discussed are not provided to UDM.

**ARTICLE VIII
COORDINATION OF BENEFITS AND SUBROGATION**

The following rules apply unless an applicable Benefit Booklet or insurance policy provides a conflicting provision, in which case that provision will apply instead.

In general, where an individual is covered by health coverage in addition to coverage under this Plan, benefits payable under this Plan must be coordinated with the other coverage. The benefits that would be otherwise payable under this Plan will be reduced (but not below zero) by the amount of benefits payable under all other Eligible Group Plans and/or Policies that are primary to the Plan. Individual insurance plans or policies for which premiums are paid directly to the organization issuing the plan or policy by the Participant and Medicaid are not coordinated with this Plan. Benefits payable under another Eligible Group Plan and/or Policy include the benefits that would have been payable if a valid claim had been made, even though no such claim was made.

"Eligible Group Plans and/or Policies" means medical and dental group plans or policies that provide benefits for treatment and which are coordinated with this Plan, including:

- Any group, blanket or franchise insurance plan or policy;
- Any hospital or medical service plan or policy or any group practice or prepayment plan or policy, except Medicare or Medicaid;
- Any union-welfare or labor-management-trusteed insurance plan or policy;
- Any government insurance group plan or policy required by law, but not including Medicare, Medicaid, workers compensation or an Indian Health Care law; and
- Any no-fault or other automobile insurance policy (primary to dental group coverage; secondary to medical coverage).

Order of Benefit Determination. If a claimant is covered by this Plan and at least one other Eligible Group Plan and/or Policy and the other Eligible Group Plan and/or Policy has a provision for coordination of benefits, the order of benefit determination is as follows:

- The benefits of a plan or policy that covers the person on whose expenses the claim is based other than as a dependent shall be determined before the benefits of a plan or policy which covers the person as a dependent.
- Except as otherwise provided below, if two plans or this Plan and a policy cover a person on whose expenses the claim is based as a dependent, the benefits of the plan or policy of the person whose birthday anniversary occurs earlier in the calendar year shall be determined before the benefits of the plan or policy of the person whose birthday anniversary occurs later in the calendar year. If the birthday anniversaries are identical, the benefits of the plan or policy which has covered the person on whose expenses the

claim is based for the longer period of time shall be determined before the benefits of the plan or policy which has covered the person for the shorter period of time.

- In the case of a claim for a dependent child:
 - If the parents of the child are divorced, and the divorce decree places financial responsibility for the medical or other health care expenses of the child upon either the custodial or the noncustodial parent, the benefits of a plan or policy which covers the minor child as a dependent of the parent with the financial responsibility will be determined before the benefits of any other plan or policy that covers the child as a dependent. This Plan will only provide such coverage when the child is a Participant in this Plan.
 - If the preceding paragraph does not apply, but the parents of the child are legally separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan or policy that covers the child as a dependent of the custodial parent will be determined before the benefits of a plan or policy that covers the child as a dependent of the noncustodial parent. However, if the parent with custody of the child has remarried, the benefits of a plan or policy which covers the child as a dependent of the custodial parent will be determined before the benefits of a plan or policy that covers the child as a dependent of the spouse of the custodial parent, and the benefits of a plan or policy that covers the child as a dependent of the spouse of the custodial parent will be determined before the benefits of a plan or policy that covers the child as a dependent of the noncustodial parent.
- If neither of the paragraphs above applies, benefits under the plan or policy that has covered the person the longest will be determined before the benefits of the plan or policy that covered the person for the shorter period of time, subject to the following exception. The benefits of a plan or policy covering the person on whose expenses the claim is based as a laid off Employee or Retiree, or as a Dependent of a laid off Employee or Retiree, will be determined after the benefits of any other plan or policy covering the person. This exception will not apply to any policy lawfully issued in a state other than Michigan that does not have a provision regarding laid off Employee or Retiree coverage, and as a result such policy and this Plan each determine benefits after the other.
- In the event coverage by any Eligible Group Plan and/or Policy does not provide for the coordination of benefits, that Eligible Group Plan and/or Policy will be considered the primary plan, and this Plan will be considered the secondary plan.
- If a Participant is covered under the Plan as an Employee and as a Dependent, the Plan will not provide coverage in excess of that which it would be required to provide as the primary plan.
- Regardless of whether the claim is being determined under this Plan as primary or secondary, the Deductibles, Co-Insurance and Co-Payments required by the applicable Coverage under this Plan, if any, shall continue to apply.
- Anything in this Plan to the contrary notwithstanding, if any Dependent is eligible for double coverage under the Plan as a result of both parents being Employees as defined herein, any lifetime or other maximum benefit limitations will apply only once to the Dependent.

- Anything to the contrary herein notwithstanding, if a Participant is covered by Medicaid and/or the Indian Health Care Law, coverage under this Plan will be primary to any such coverage to the extent required by law, consistent with the relevant provisions set forth below.
- Anything to the contrary herein notwithstanding, if a Participant is covered by a no-fault or other automobile insurance policy and/or workers compensation, the no-fault or other automobile insurance policy and/or workers compensation will be primary to any coverage under this Plan.

Right to Receive and Release Necessary Information. The Plan may, without the consent of or notice to any person, release to or obtain from any other organization or person any information with respect to any person which this Plan deems to be necessary for purposes of coordination of benefits or for similar purposes, to the extent permitted by HIPAA. Any person claiming benefits under this Plan must furnish to this Plan any information, consents or releases necessary to implement this right.

Medicaid. Anything to the contrary herein notwithstanding:

- Payment for benefits of a Participant shall be made in accordance with any assignment of rights made by or on behalf of such Participant as required by a state Medicaid program.
- In enrolling an individual in the Plan or in determining or making any payments for benefits, the fact that the individual is eligible for or is provided medical assistance under a state Medicaid program will not be taken into account.
- To the extent payment has been made under a state Medicaid program and the Plan provides for payment of the same benefits, the Plan will make payment in accordance with any state law that provides the state subrogation rights.
- A "state Medicaid program" means a state plan for medical assistance approved under Title XIX of the Social Security Act.

Indian Health Care. Anything herein to the contrary notwithstanding, to the extent required by 25 USC 1621(e), the Plan shall provide reimbursement to the United States, an Indian tribe, or a tribal organization, of the reasonable expense incurred by the Secretary of the Indian Health Service, the Indian tribe or the tribal organization in providing health services, through the Indian Health Service, an Indian tribe, or tribal organization, to any Participant to the same extent that such Participant or any nongovernmental provider of such services, would be eligible to receive reimbursement or payment of such expenses if:

- The services had been provided by a nongovernmental provider, and
- The Participant had been required to pay such expenses and did pay such expenses.

Subrogation Rules. In certain situations, the Plan has the right to be reimbursed for or recover the amount of benefits paid to or on behalf of you, a covered Spouse or Dependent. These situations include cases when the Plan has overpaid benefits, when the amount paid by the Plan should have been paid by another plan, program or insurance, or when you or a covered Spouse or Dependent incurred the health care expenses paid for by the Plan due to the negligence or wrongdoing of another party. If one or more of these situations occur, the Plan has the right to offset future amounts payable by the Plan to or on behalf of you or a covered Spouse or

dependent. The Plan also has the right to sue a third party to recover amounts that may be recoverable by you or a covered Spouse or dependent if you or the covered Spouse or dependent were to sue the third party. This is called the Plan's right of subrogation. These rights are explained in more detail below.

When you accept Plan benefits, you and your covered Spouse or Dependents accept the terms set forth in this section. In certain situations, for example, when the injuries, sickness, or disability for which you or a covered Spouse or dependent are seeking benefits under the Plan resulted from the negligence or wrongdoing of a third party, the Plan may request that you or your covered Spouse or dependent acknowledge and/or agree in writing to the terms set forth in this section. Any such agreement may, in the sole discretion of the Plan Administrator or its delegate, require the establishment of a trust or a lien on any monies paid by the third party or its insurer. If you or your covered Spouse or Dependent refuses to sign such an acknowledgement or agreement when requested, benefits provided under the Plan on behalf of you or your covered Spouse or Dependent will cease.

Offset for Benefits Otherwise Paid or Payable. The Plan has the right to recover or offset overpayments and payments it makes for benefits provided under the Plan which are also covered by another group health plan, a governmental program, a statutory plan such as Workers' Compensation, or other insurance coverage, including automobile insurance. If you or a covered Spouse or dependent receive full or partial payment from one of these sources for benefits that have also been provided by the Plan, or if a full or partial payment is made on your behalf or on behalf of a covered Spouse or Dependent by one of these sources, the claims administrator may withhold payment of future Plan benefits until the Plan has recovered or offset the amount of the payment or overpayment.

Subrogation and Reimbursement Rights. If you or a covered Spouse or Dependent have expenses for injuries, sickness, or disability resulting from the negligence or wrongdoing of a third party, or if you or a covered Spouse's or Dependent's expenses for injuries, sickness, or disability are otherwise payable in whole or in part by a third party (for example, by Workers' Compensation insurance), the Plan has the right to recover benefit payments made by the Plan related to the injuries, sickness, or disability.

By accepting benefits under the Plan, you and your covered Spouse and Dependents agree:

- To reimburse the Plan for benefits paid by the Plan if you or a covered Spouse or Dependent receive or become entitled to any amounts from another source related to the injuries, sickness, or disability, **whether or not** those amounts are designated as payment of medical expenses. This is the Plan's reimbursement right.
- To give the Plan the right to take legal action to obtain an equitable remedy against the third party on your behalf or on behalf of the covered person if you or the covered person does not take such legal action. This is the Plan's subrogation right.
- To the imposition of a first priority equitable lien or constructive trust on specific property recovered, or to be recovered, from any party who caused the injuries, sickness, or disability and any party (such as an insurance company) who is otherwise obligated to pay any amounts related to the injuries, sickness, or disability. The amount of the Plan's equitable lien or constructive trust rights will equal the benefit amounts paid by the Plan.

- That the Plan will be reimbursed and recover 100% of any amounts (a) paid by the Plan or (b) which the Plan is otherwise obligated to pay and thereafter pays, to the maximum total amount that you or a covered Spouse or Dependent is paid or to which you or a covered Spouse or Dependent becomes entitled in connection with a claim made against a third party arising out of an injury, sickness or disability.
- That the Plan has a right to recover, or have a first priority equitable lien or constructive trust imposed upon, any specific property or amount that you or a covered Spouse or Dependent are paid or to which you or a covered Spouse or dependent become entitled **without** deduction for attorney's fees and costs or other deductions incurred by you or your covered Spouse or dependent, **without** regard to whether you or a covered Spouse or Dependent are fully compensated by the recovery on the claim against the third party (i.e., even if you or your covered family member are not "made whole"), **without** regard to whether the recovery is a full or partial recovery, and **without** regard to any allocation or designation of the recovery. If the recovery from the third party is less than the benefits paid by the Plan, the Plan is still entitled to be paid all of the recovery from the third party.
- That your rights and your covered Spouse's or Dependents' rights to be made whole are superseded by the Plan's subrogation and reimbursement rights. The Plan explicitly rejects the "make whole" doctrine.

Equitable Lien or Constructive Trust. The Plan's right of recovery, reimbursement, and subrogation constitutes a first priority and first equitable lien or constructive trust against any settlement, judgment, award, or other specific property or amount that you or a covered Spouse or dependent are paid, to which you or your covered Spouse or dependent become entitled, or that is designated as paid or payable on your behalf or on behalf of your covered Spouse or dependent for recovery of amounts paid by the Plan.

The Plan is not bound by any allocation of items of damages you may agree to if it is not represented in, or a party to, the proceedings or settlement in which the allocation was determined. Therefore, you are advised to inform the Plan Administrator whenever you are involved in any proceedings or settlements that may implicate the provisions of this section of the Plan.

Notice of Legal Proceedings. A Participant must, within 10 days of institution of any legal proceedings on behalf of the Participant against a third party or its insurer for recovery of any amount that otherwise would be payable to the Plan hereunder, notify the Plan Administrator or its delegate of the legal proceedings, including the names of the parties, the name and location of the forum, the status of the case, the names, addresses and phone numbers of all attorneys and the case number. A Participant shall also, within 30 days prior to settlement of any legal proceedings against a third party or its insurer, notify the Plan Administrator or its delegate of the terms of the proposed settlement.

Enforcement Actions. A Participant who accepts payment from the Plan of benefits (other than Insured benefits) shall be deemed to have agreed that the Plan may take all action deemed necessary or appropriate in the discretion of the Plan Administrator or its delegate to enforce its rights under this section. Such actions shall include, but shall not be limited to:

- Obtaining a judicial determination that any proceeds from any recovery by the Participant, or on his behalf, or by his assignee, from the third party or its insurer shall be deemed held in a constructive trust for the Plan;
- Obtaining a judicial determination that any portion of any recovery by the Participant, or on his behalf, or by his assignee, from the third party or its insurer shall be subject to an equitable lien;
- Obtaining a preliminary or permanent injunction, a declaration of rights or specific performance against the Participant, his attorney or any assignee of either of them;
- Obtaining restitution against the Participant, his attorney or any third party;
- Obtaining a stay of any legal proceedings brought by the Participant against the third party or its insurer and enjoining the Participant and his assignees from adjudication of the matter;
- Obtaining other appropriate equitable relief to redress any violation of the Plan or to enforce the terms of the Plan;
- Obtaining such judicial relief against the Participant or any assignee, as may be provided under state law, including a claim for breach of contract;
- Proceeding in subrogation directly against any third party for payment of all or a portion of the medical benefits paid under the Plan; and/or
- Intervening in any lawsuit brought by the Participant against the third party or its insurer.

Sanctions for Failure to Comply with Plan Provisions. A Participant shall do nothing to prejudice the rights of the Plan under this section. If any Participant fails to timely provide the notice required under this section, or is requested to execute any agreement under this section but refuses to do so, no further benefits shall be paid on his behalf under the Plan until the Plan either recovers all amounts the Participant is required to repay or offsets against future benefits payable under the Plan, any payments made by the Plan that it was unable to recover.

In the sole discretion of the Plan Administrator or its delegate, any action by a Participant to frustrate or avoid the recovery by the Plan of medical benefits payments as required under this section will be grounds for termination of all benefits of the Participant payable under the Plan.

<p>ARTICLE IX CLAIMS PROCEDURES</p>
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If your claim for eligibility to participate in the Plan is denied, this section describes your appeal rights. Your request for review must be in writing and must include the reasons you believe your claim was improperly denied. ⁴

⁴ See temporary provisions in Claims During Outbreak Period section.

Within 90 days after receipt of your initial claim for eligibility to participate in the Plan, the Plan Administrator will send you a notice of the granting or denying, in whole or in part, of your claim, unless special circumstances require an extension of time for processing the claim. The extension may not exceed 90 days from the end of the initial 90-day period.

If an extension is necessary, you will be given a written notice to this effect indicating the special circumstances necessitating the extension prior to the expiration of the initial 90-day period. The Plan Administrator has full discretion to deny or grant a claim in whole or in part.

If your claim for eligibility to participate in the Plan is denied, the Plan Administrator will provide you with a written notice setting forth the following information in a manner calculated to be understood by you:

- The specific reason or reasons for the denial;
- Specific reference to pertinent Plan provisions on which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material is necessary;
- An explanation of the Plan's claim review procedures; and
- A statement of your rights to bring a civil action under Section 502(a) of ERISA following an adverse determination on review.

Within 60 days after you receive written notification of the denial (in whole or in part) of your claim, you or your duly authorized representative may make a written application to the Plan Administrator, in person or by certified mail, postage prepaid, to be afforded a review of the denial. You may review pertinent documents and may submit issues and comments in writing. Upon request, and free of charge, you or your authorized representative will be provided reasonable access to, and copies of, documents, records and other information relevant to your claim.

Your claim for review must be given a full and fair review. The Plan Administrator's review will take into account all comments, documents, records and other information submitted as part of your request for a review, without regard to whether the information was submitted or considered in the initial benefit determination. The decision upon review will be made no later than 60 days after the Plan Administrator's receipt of a request for a review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after receipt of a request for review. If an extension is necessary, you will be given written notice of the extension indicating the special circumstances prior to the expiration of the initial 60-day period. The decision will be written in a manner calculated to be understood by you, will include specific reasons for the decision, specific references to the pertinent Plan provisions on which the decision was based and will include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim and a statement of your rights to bring a civil action under ERISA Section 502(a).

CLAIMS FOR MEDICAL CARE AND PRESCRIPTION DRUG BENEFITS

Claims for Medical Care and Prescription Drug benefits under the Plan are reviewed and determined by the respective insurers and claims administrators shown in the chart on page 1 of this document under “Plan Coverage” with respect to the associated benefits (referred to as the “Reviewer” in the remainder of this section) according to the claims and appeal (or claims and review) procedures described in the benefit booklet governing the specific benefit. For example, claims for Medical PPO1 benefits are governed by the claims procedures issued by Blue Cross Blue Shield of Michigan. The Reviewer has the exclusive authority to approve or deny claims for that benefit. The Employer has no involvement in the claims and claims review processes for these benefits.

If a Benefit Booklet fails to provide any claims and appeal (or claim and review) procedures with regard to a group Health Plan benefit or provides an incomplete or legally deficient procedure, the applicable provisions below will apply.

In the event that you, your Spouse or Dependent, or an authorized representative makes a claim for group health plan benefit, that party will be considered a “claimant.” Claimants are entitled to a full and fair review of any claims made under the Plan. The following procedures governing the filing of benefit claims, notification of benefit decisions, and appeal of adverse benefit decisions. There are four categories of claims, each with somewhat different claim and appeal rules. Different requirements apply based on the type of claim involved. The primary difference is the timeframe within which claims and appeals must be determined.

Pre-Service Claim. A claim is a pre-service claim if entitlement to the benefit, in whole or in part, is contingent on receiving approval in advance of obtaining the medical care--unless the claim involves urgent care, as defined below.

Urgent Care Claim. An urgent care claim is a special type of pre-service claim. A claim involving urgent care is any pre-service claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to pre-service claims could seriously jeopardize the claimant's life or health or ability to regain maximum function or would--in the opinion of a physician with knowledge of the claimant's medical condition--subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

On receipt of a pre-service claim, the Reviewer will make a determination of whether it involves urgent care, provided that, if a physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim shall be treated as an urgent care claim.

Post-Service Claim. A post-service claim is any claim for a benefit under this Plan that is not a pre-service claim or an urgent care claim.

Concurrent Care Claims. A concurrent care decision occurs where the plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (a) where reconsideration of the

approval results in a reduction or termination of the initially-approved period of time or number of treatments; and (b) where an extension is requested beyond the initially-approved period of time or number of treatments.

Change in Claim Type. The claim type is determined initially when the claim is filed. However, if the nature of the claim changes as it proceeds through these claims procedures, the claim may be re-characterized. For example, a claim may initially be an urgent care claim. If the urgency subsides, it may be re-characterized as a pre-service claim.

Questions About Claim Type and Claim Procedures. For purposes of this section, an “adverse benefit determination” includes:

- A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit; or
- A rescission of coverage.

It is very important to follow the requirements that apply to your particular type of claim. If you have any questions regarding what type of claim and/or what claims procedure to follow, contact the Reviewer at the address listed in the “Administrative Information” section at the back of this document.

The Plan must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. As a result, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual must not be made based upon the likelihood the individual will support the denial of benefits.

Internal Claims and Appeals for Medical and Prescription Drug Benefits.

1. How to File a Claim for Benefits

Except for urgent care claims, discussed below, a claim for benefits is made when you (or your authorized representative) submit a written Claim for Benefits form to the Reviewer at the address listed in the “Administrative Information” section at the back of this document.

A post-service claim must be filed within 90 days following receipt of the medical service, treatment or product to which the claim relates unless (a) it was not reasonably possible to file the claim within such time; and (b) the claim is filed as soon as possible and in no event (except in the case of legal incapacity of the claimant) later than twelve (12) months after the date of receipt of the service, treatment or product to which the claim relates.

In light of the expedited timeframes for decision of urgent care claims, an urgent care claim for benefits may be submitted by telephone to the Reviewer at the telephone number listed in the “Administrative Information” section at the back of this document. The claim should include at least the following information:

- the identity of the claimant
- a specific medical condition or symptom
- a specific treatment, service or product for which approval or payment is requested.

2. Timeframe for Deciding Initial Benefit Claims

The Reviewer will decide an initial pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.

The Reviewer will decide an initial urgent care claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. However, if a claim is a request to extend a concurrent care decision involving urgent care and if the claim is made at least 24 hours prior to the end of the initially-approved period of time or number of treatments, the claim will be decided within no more than 24 hours after receipt of the claim. Any other request to extend a concurrent care decision will be decided in the otherwise applicable timeframes for pre-service, urgent care, or post-service claims.

A decision by the Reviewer to reduce or terminate an initially-approved course of treatment is an adverse benefit decision that may be appealed by the claimant under these procedures, as explained below. Notification to the claimant of a decision by the Reviewer to reduce or terminate an initially-approved course of treatment shall be provided sufficiently in advance of the reduction or termination to allow the claimant to appeal the adverse decision and receive a decision on review under these procedures prior to the reduction or termination.

The Reviewer will decide an initial post-service claim within a reasonable time but no later than 30 days after receipt of the claim (45 days in the case of a disability) after receipt of the claim.

Despite the specified timeframes, nothing prevents the claimant from voluntarily agreeing to extend the above timeframes. In addition, if the Reviewer is not able to decide a pre-service or post-service claim within the above timeframes, due to matters beyond its control, one 15-day extension of the applicable timeframe is permitted, provided that the claimant is notified in writing prior to the expiration of the initial timeframe applicable to the claim. The extension notice will include a description of the matters beyond the Reviewer's control that justify the extension and the date by which a decision is expected. No extension is permitted for urgent care claims.

If any information needed to process a claim is missing, the claim shall be treated as an incomplete claim.

If an urgent care claim is incomplete, the Reviewer will notify the claimant as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notification may be made orally to the claimant unless the claimant requests written notice, and it will describe the information necessary to complete the claim and will specify a reasonable time, no less than 48 hours, within which the claim must be completed. The Reviewer will decide the claim as soon as possible but not later than 48 hours after the earlier of (a) receipt of the specified information, or (b) the end of the period of time provided to submit the specified information.

If a pre-service or post-service claim is incomplete, the Reviewer may deny the claim or may take an extension of time, as described above. If the Reviewer takes an extension of time, the extension notice will include a description of the missing information and shall specify a timeframe, no less than 45 days, in which the necessary information must be provided. The timeframe for deciding the claim will be suspended from the date the extension notice is received by the claimant until the date the missing necessary information is provided to the Reviewer. If the requested information is provided, the Reviewer will decide the claim within the extended

period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

3. Notification of Initial Benefit Decision

Written notification of the decision on a pre-service or urgent care claim will be provided to the claimant whether or not the decision is adverse. A decision on a claim is “adverse” if it is (a) a denial, reduction, or termination of, or (b) a failure to provide or make payment (in whole or in part) for a benefit.

Written notification will be provided to the claimant of the adverse decision on a claim and will include the following, in a manner calculated to be understood by the claimant:

- a statement of the specific reason(s) for the decision and information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and the corresponding meaning, and the treatment code and the corresponding meaning);
- a description of any additional material or information necessary to perfect the claim and why such information is necessary;
- a description of the plan procedures and time limits for appeal of the decision, the external review process, and the right to obtain information about those procedures, and, if applicable, the right to sue in federal court;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- if the decision involves scientific or clinical judgment, disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the plan to the claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request;
- in the case of an urgent care claim, an explanation of the expedited review methods available for such claims;
- the denial code and the corresponding meaning, as well as a description of the Plan's standard or section, if any, that was used in denying the claim; and
- a disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review processes.

Notification of an adverse decision on an urgent care claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

4. Your Right to Appeal

A claimant has a right to appeal an adverse decision under these claims procedures.

Except for urgent care claims, discussed below, an appeal of an adverse benefit decision is filed when a claimant (or authorized representative) submits a written Request for Review form to the Reviewer.

A claimant has the right to submit documents, written comments, or other information in support of an appeal.

The appeal of an adverse benefit decision must be filed within 180 days following the claimant's receipt of the notification of adverse benefit decision, except that the appeal of a decision to reduce or terminate an initially-approved course of treatment (see the definition of concurrent care decision) must be filed within 30 days of the claimant's receipt of the notification of the decision to reduce or terminate. Failure to comply with this important deadline may cause the claimant to forfeit any right to any further review of an adverse decision under these procedures or in a court of law.

In light of the expedited timeframes for decision of urgent care claims, an urgent care appeal may be submitted by telephone to the Reviewer. The claim should include at least the following information:

- the identity of the claimant;
- a specific medical condition or symptom;
- a specific treatment, service or product for which approval or payment is request; and
- any reasons why the appeal should be processed on a more expedited basis.

5. *How Your Appeal Will Be Decided*

The appeal of an adverse benefit decision will be reviewed and decided by the Reviewer. The person who reviews and decides an appeal will be a different individual than the person who made the initial benefit decision and will not be a subordinate of the person who made the initial benefit decision. The Reviewer will follow these procedures when deciding any appeal:

The review will take into account all information submitted by the claimant, whether or not presented or available at the initial benefit decision. The Reviewer will give no deference to the initial benefit decision.

In the case of a claim denied on the grounds of a medical judgment, the Reviewer will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the same individual who was consulted, if any, regarding the initial benefit decision or a subordinate of that individual.

A claimant shall, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. If the advice of a medical or vocational expert was obtained in connection with the initial benefit decision, the names of each such expert shall be provided on request by the claimant, regardless of whether the advice was relied on by the Plan.

The Plan will provide the claimant, free of charge, with any new or additional evidence or reasoning considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. The Plan will provide the evidence as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

All necessary information in connection with an urgent care appeal will be transmitted between the Plan and the claimant by telephone, fax, or e-mail.

6. Timeframes for Deciding Benefit Appeals

The Reviewer will decide the appeal of a pre-service claim within a reasonable time appropriate to the medical circumstances but no later than 30 days after receipt by the Reviewer of the Request for Review form.

The Reviewer will decide the appeal of an urgent care claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt by the Reviewer of the Request for Review.

The Reviewer will decide the appeal of a post-service claim within a reasonable period but no later than 60 days after receipt by the Reviewer of the Request for Review form.

The Reviewer will decide the appeal of a decision to reduce or terminate an initially-approved course of treatment (see the definition of concurrent care decision) before the proposed reduction or termination takes place. The Reviewer will decide the appeal of a denied request to extend a concurrent care decision in the appeal timeframe for pre-service, urgent care, or post-service claims described above, as appropriate to the request.

7. Notification of Decision on Appeal

Written notification of the decision on appeal shall be provided to the claimant whether or not the decision is adverse. A decision on appeal is “adverse” if it is (a) a denial, reduction, or termination of, or (b) a failure to provide or make payment (in whole or in part) for a benefit.

Written notification shall be provided to the claimant of an adverse decision on appeal and shall include the following, written in a culturally linguistic and appropriate manner calculated to be understood by the claimant (to the extent required by law):

- the specific reason(s) for the appeal decision, information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the opportunity to request the diagnosis code and the corresponding meaning, and the opportunity to request the treatment code and the corresponding meaning);
- reference to the specific Plan provisions(s) on which the denial is based;
- a description of the external review process, and, if applicable, a statement explaining the right to sue in federal court upon exhaustion of the external review process;
- a statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request);
- if the decision involves scientific or clinical judgment, disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the plan to the claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge on request;
- the denial code and the corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim, in addition to a discussion of the decision; and

- a disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review processes.

Notification of an adverse decision on appeal of an urgent care claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

8. *Miscellaneous Internal Claims and Appeals Rules*

If the Plan fails to strictly adhere to the requirements for deciding a claim, the claimant is deemed to have exhausted the internal claims and appeals processes. Accordingly, the claimant may initiate an external review as described below or may pursue any available remedies under ERISA or under State law.

The Plan is required to provide continued coverage pending the outcome of an appeal.

If you have questions about these claims procedures, contact the Reviewer.

External Review Procedures for Medical and Prescription Drug Benefits.

1. *External Review Procedures for Insured Benefits*

If a State external review process is binding on an insurance issuer of an applicable group health benefit offered under the Plan **and** the State external review process includes minimum consumer protections required under PPACA, then the insurance issuer must comply with the applicable State external review process.

In these circumstances, the Plan will be relieved from complying with the requirements of this subsection.

2. *External Review Procedures for Self-Insured Benefits*

The external review process described in this subsection applies in the absence of a contrary provision in a Benefit Booklet, to any adverse benefit determination, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a claimant fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the external review process.

- **Request for External Review.** The claimant may file a request for an external review with the Plan, provided the request is filed within 4 months after the date of receipt of a notice of an adverse benefit determination or final adverse benefit determination. If there is no corresponding date 4 months after the date of receipt of such notice, then the request must be filed by the first day of the 5th month following the receipt of the notice. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal Holiday.
- **Preliminary Review.** Within 5 business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

- a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- b) The adverse benefit determination or the final benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan;
- c) The claimant has exhausted the Plan's internal appeal process, unless the claimant is deemed to have exhausted the internal appeals process; and
- d) The claimant has provided all the information and forms required to process an external review.

Within 1 business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA). If the request is not complete, the notification will describe the information or materials needed to make the request complete. The claimant will have until the end of the 4-month filing period for requesting an external review, or 48 hours following the receipt of the notification, whichever is later, to perfect the request for external review.

- Referral to Independent Review Organization. The Plan will assign an "independent review organization" ("IRO") that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. The Plan will take action against bias to ensure independence by contracting with at least 3 IROs for assignments under the Plan and rotate claims assignments among them, or will incorporate other independent, unbiased methods for selection of IROs (such as random selection). The IRO will not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.
 - a) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.
 - b) The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the claimant may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
 - c) Within five business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. The failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final adverse benefit determination. Within 1 business day after making the decision, the IRO will notify the claimant and the Plan.
 - d) Upon receipt of any information submitted by the claimant, the assigned IRO must within 1 business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan must not delay the external review. The external

review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within 1 business day after making such a decision, the Plan will provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Plan.

- e) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and in accordance with established guidelines, and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process described in the previous subsection.
 - f) The assigned IRO must provide written notice to the claimant and the Plan of the final external review decision within 45 days after the IRO receives the request for the external review.
 - g) The assigned IRO's decision notice will contain information required by PPACA, including information sufficient to identify claims and treatment codes, a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to the claimant, a statement that judicial review may be available to the claimant, and current contact information for any applicable office of health insurance consumer assistance or ombudsman.
- Reversal of Plan's Decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.
 - Expedited External Review Procedures. The claimant may make a request for an expedited review with the Plan at the time the claimant receives:
 - a) An adverse benefit determination, if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
 - b) A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, the availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.
 - Expedited External Review - Preliminary Review. Immediately following receipt of the expedited external review request, the Plan will complete a preliminary review of the validity of the claimant's request, utilizing the same standard for preliminary review described above in the "Standard External Review Procedures during Interim Period" subsection.

Immediately after completion of the preliminary review, the Plan will issue to the claimant the written notification described above in the “Standard External Review Procedures during Interim Period” subsection.

- Expedited External Review - Referral to Independent Review Organization. The Plan will assign an IRO to conduct the expedited external review under the same procedure described above for referring to an IRO in the “Standard External Review Procedures during Interim Period” subsection.

The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and in accordance with established guidelines, and is not bound by any decisions or conclusions reached during the Plan’s internal claims and appeals process.

- Expedited External Review - Notice of Final External Review Decision. The IRO will provide notice of the final external review decision as expeditiously as the claimant’s medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.

The assigned IRO’s written decision will contain information required by PPACA, including information sufficient to identify claims and treatment codes, a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to the claimant, a statement that judicial review may be available to the claimant, and current contact information for any applicable office of health insurance consumer assistance or ombudsman.

CLAIMS FOR DISABILITY BENEFITS

Claims for disability benefits under the Plan are reviewed and determined by the claims administrator or insurer of the applicable benefit (referred to as the “Reviewer” in the remainder of this section) according to the claims and appeal (or claims and review) procedures described in the benefit booklet governing the specific benefit. The Reviewer has the exclusive discretionary authority and fiduciary responsibility to approve or deny claims for that benefit. The Company has no involvement in the claims and claims review processes for these benefits. Please consult the claims and appeal (or claims and review) procedures in the applicable benefit booklet issued by the associated insurer for the specific procedures. As a result, the claims and appeals procedures provided in the benefit booklet for the applicable disability benefit will apply, except in instances where the benefit booklet provides no claims and appeal procedure or where such

provisions do not comply with the minimum requirements described in this section. In such circumstances, the minimum requirement described in this section will apply.

Effective for claims for disability benefits filed on or after April 1, 2018, the Plan must ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. As a result, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual must not be made based upon the likelihood the individual will support the denial of benefits.

For purposes of this “Claims for Disability Benefits” Section, an “adverse benefit determination” includes:

- A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit (including a denial, reduction, or termination of, or failure to provide or make payment that is based on a determination of your eligibility to participate); or
- Effective for claims for disability benefits filed on or after April 1, 2018, a rescission of disability coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time).⁵

Effective for claims for disability benefits filed on or after April 1, 2018, a notice is provided in a “culturally and linguistically appropriate manner” if the following requirements are met with respect to applicable non-English languages:⁶

- Oral language services (such as a telephone customer assistance hotline) are provided that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language;
- Upon request, a notice is provided in any applicable non-English language; and
- In the English versions of all notices, a statement is prominently displayed in any applicable non-English language clearly indicating how to access the language services provided.

In the event the Benefit Booklet for the applicable disability benefit does not contain a provision for the time frame to file a claim, a claim for disability benefits must be filed within 90 days following the date of the event triggering a disability benefit unless: (a) it was not reasonably possible to file the claim within such time; and (b) the claim is filed as soon as possible and in no event (except in the case of your legal incapacity) later than twelve (12) months after the date of the triggering event.

In the event that you, your Spouse, your Dependent, or an authorized representative makes a claim for a disability benefit, that party will be considered a “claimant.”

5 A “rescission” for this purpose means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent the cancellation or discontinuance is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

6 A non-English language is an applicable non-English language with respect to an address in any United States county to which a notice is sent if 10% or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary of the Department of Labor.

Within 45 days after receipt of your initial claim for benefits, the Reviewer will send you a notice of the granting or denying, in whole or in part, of your claim, unless special circumstances require a 30-day extension of time for processing the claim. If a 30-day extension is necessary, you will be given a written notice to this effect indicating the special circumstances necessitating the extension prior to the expiration of the initial 45-day period. If another 30-day extension is necessary, you will be given a written notice to this effect indicating the special circumstances necessitating a second extension prior to the expiration of the first 30-day extension period. The Reviewer has full discretion to deny or grant a claim in whole or in part.

Within 180 days after you receive written notification of the denial (in whole or in part) of your claim, you or your duly authorized representative may make a written application to the Reviewer, in person or by certified mail, postage prepaid, to be afforded a review of the denial. You may review pertinent documents and may submit issues and comments in writing. Upon request, and free of charge, you or your authorized representative will be provided reasonable access to, and copies of, documents, records and other information relevant to your claim.

A claimant shall, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. If the advice of a medical or vocational expert was obtained in connection with the initial benefit decision, the names of each such expert shall be provided on request by the claimant, regardless of whether the advice was relied on by the Plan.

The written decision upon review will be made no later than 45 days after the Reviewer's receipt of a request for a review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 90 days after receipt of a request for review. If an extension is necessary, you will be given written notice of the extension indicating the special circumstances prior to the expiration of the initial 45-day period. The Reviewer has full discretion to deny or grant a claim in whole or in part.

If your claim for benefits is denied, the Reviewer will provide you with a written notice setting forth the following information in a manner calculated to be understood by you:

- (a) the specific reason or reasons for the denial and, effective for claims for disability benefits filed on or after April 1, 2018, a discussion of the decision (including an explanation of the basis for disagreeing with or not following: (i) the views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination); and (iii) a disability determination regarding you presented by you to the Plan made by the Social Security Administration);
- (b) specific reference to pertinent Plan provisions on which the denial was based;
- (c) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material is necessary;
- (d) an explanation of the Plan's claim review procedures;
- (e) a statement of your rights to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;

- (f) a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); and
- (g) if the decision involves scientific or clinical judgment, disclose either (i) an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, or (ii) a statement that such explanation will be provided at no charge upon request.

Within 180 days after you receive written notification of the denial (in whole or in part) of your claim, you or your duly authorized representative may make a written application to the Reviewer, in person or by certified mail, postage prepaid, to be afforded a review of the denial. You may review pertinent documents and may submit issues and comments in writing. Upon request, and free of charge, you or your authorized representative will be provided reasonable access to, and copies of, documents, records and other information relevant to your claim.

The appeal of an adverse benefit determination will be reviewed and decided by the Reviewer. Your claim for review must be given a full and fair review. The person who reviews and decides an appeal will be a different individual than the person who made the initial benefit decision and will not be a subordinate of the person who made the initial benefit decision. The Reviewer will follow these procedures when deciding any appeal.

The review will take into account all information submitted by the claimant, whether or not presented or available at the initial benefit decision. The Reviewer will give no deference to the initial benefit decision.

In the case of a claim denied on the grounds of a medical judgment, the Reviewer will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the same individual who was consulted, if any, regarding the initial benefit decision or a subordinate of that individual.

A claimant shall, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. If the advice of a medical or vocational expert was obtained in connection with the initial benefit decision, the names of each such expert shall be provided on request by the claimant, regardless of whether the advice was relied on by the Plan.

The written decision upon review will be made no later than 45 days after the Reviewer's receipt of a request for a review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 90 days after receipt of a request for review. If an extension is necessary, you will be given written notice of the extension indicating the special circumstances prior to the expiration of the initial 45-day period.

Written notification shall be provided to the claimant of an adverse benefit determination on appeal and shall include the following, written in a manner calculated to be understood by the claimant:

- the specific reason(s) for the appeal decision;
- a reference to the specific plan provision(s) on which the decision is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request);
- a statement of the right to sue in federal court;
- a statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and
- if the decision involves scientific or clinical judgment, disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge on request.

If you have questions about these claims procedures, contact the Reviewer.

**CLAIMS FOR OTHER BENEFITS (NOT MEDICAL CARE OR
PRESCRIPTION DRUG BENEFITS)**

Claims for benefits under the Plan are reviewed and determined by the claims administrator or insurer of the applicable benefit (referred to as the "Reviewer" in the remainder of this section) according to the claims and appeal (or claims and review) procedures described in the benefit booklet governing the specific benefit. The Reviewer has the exclusive discretionary authority and fiduciary responsibility to approve or deny claims for that benefit. The Employer has no involvement in the claims and claims review processes for these benefits. Please consult the claims and appeal (or claims and review) procedures in the applicable Benefit Booklet for the specific procedures. As a result, the claims and appeals procedures provided in the Benefit Booklet for the applicable benefit will apply, except in instances where the benefit booklet provides no claims and appeal procedure or where such provisions do not comply with the minimum legal requirements. In such circumstances, the minimum requirement described in this section will apply.

In the event that you, your Spouse, your Dependent, or an authorized representative makes a claim for a benefit under the Plan that is not a group health benefit or a disability benefit, that party will be considered a "claimant."

Within 90 days after receipt of your initial claim for benefits, the Reviewer will send you a notice of the granting or denying, in whole or in part, of your claim, unless special circumstances require an extension of time for processing the claim. The extension may not exceed 90 days from the end of the initial 90-day period.

If an extension is necessary, you will be given a written notice to this effect indicating the special circumstances necessitating the extension prior to the expiration of the initial 90-day period. The Reviewer has full discretion to deny or grant a claim in whole or in part.

If your claim for benefits is denied, the Reviewer will provide you with a written notice setting forth the following information in a manner calculated to be understood by you.

- (a) the specific reason or reasons for the denial;
- (b) specific reference to pertinent Plan provisions on which the denial is based;
- (c) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material is necessary;
- (d) an explanation of the Plan's claim review procedures; and
- (e) a statement of your rights to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

Within 60 days after you receive written notification of the denial (in whole or in part) of your claim, you or your duly authorized representative may make a written application to the Reviewer, in person or by certified mail, postage prepaid, to be afforded a review of the denial. You may review pertinent documents and may submit issues and comments in writing. Upon request, and free of charge, you or your authorized representative will be provided reasonable access to, and copies of, documents, records and other information relevant to your claim.

Your claim for review must be given a full and fair review. The Reviewer's review will take into account all comments, documents, records and other information submitted as part of your request for a review, without regard to whether the information was submitted or considered in the initial benefit determination. The decision upon review will be made no later than 60 days after the Reviewer's receipt of a request for a review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after receipt of a request for review. If an extension is necessary, you will be given written notice of the extension indicating the special circumstances prior to the expiration of the initial 60-day period. The decision will be written in a manner calculated to be understood by you, will include specific reasons for the decision, specific references to the pertinent Plan provisions on which the decision was based and will include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim and a statement of your rights to bring a civil action under ERISA Section 502(a).

If you have questions about claim procedures, contact the Reviewer.

CLAIMS DURING OUTBREAK PERIOD

Notwithstanding anything set forth elsewhere in this Article IX, to the extent required by law, certain deadlines under the Plan are temporarily extended during the coronavirus "Outbreak Period." The Outbreak Period runs from March 1, 2020 until sixty (60) days after the announced end of the Presidentially-declared National Emergency (or such other date determined by the federal government in a future notice). These extended deadlines apply regardless of any

contrary deadlines reflected in any COBRA Notice or form provided.

The Plan will disregard the Outbreak Period when determining following time periods/deadlines:

COBRA --

- **The 60 days period** (starting on the later of the date a COBRA Election form is mailed or group health coverage is lost), **within which a COBRA Election for must be sent to the Plan Administrator;**
- **The 45 day period** (starting on the date of the COBRA election) **for paying the initial COBRA premiums for the entire period from the date coverage ended through the payment date, and the subsequent 30 day grace period during which payments will be treated as timely;**
- **The 60 day period** (starting on the later of the date of the event or the resulting loss of coverage) **you have under COBRA to notify the Plan Administrator of your divorce or separation, or a loss of “dependent” status, affecting eligibility for group health coverage;**
- **The period the Plan Administrator has to send a notice of COBRA election rights after receiving notice of a COBRA-qualifying event** (14 days after receipt from the employer or from a participant or other qualifying beneficiary);
- **If you are already on COBRA, the 60 day period for notifying the Plan Administrator** (from the date of a Social Security Administration determination of disability status, or if later, from the date of the COBRA qualifying event or loss of coverage) **of your disability status,** which may trigger an 11 month COBRA extension;

SPECIAL ENROLLMENT RIGHTS --

- **The 30-day period (or 60-day period, if applicable) to request special enrollment under ERISA** (You may enroll yourself or an eligible Spouse or Dependent Child, or may change coverage elections mid-year if already enrolled, in the medical and prescription drug benefits under the Plan at a time other than during an open enrollment period if you notify the Plan Administrator within 30 days of the loss of coverage, or the addition of a new dependent due to marriage, birth, adoption or placement for adoption; or you may enroll within 60 days of gaining or losing eligibility for Medicaid or State CHIP coverage assistance);

CLAIM AND APPEAL DEADLINES –

- **The date within which individuals may file a benefit claim under the plan's claims procedure** (e.g., a post-service claim or a claim for disability benefits not addressed in a separate benefit booklet must be filed within 90 days unless (a) it was not reasonably possible to file the claim within such time; and (b) the claim is filed as soon as possible and in no event (except in the case of legal incapacity of the claimant) later than twelve (12) months after the date of receipt of the service, treatment or product to which the claim relates); for other benefits the deadlines provided in the benefit booklet for the applicable benefit apply, if any);
- **The date by which claimants may provide additional information after they receive notice from the claim Reviewer that their pre-service or post-service claim is incomplete** (the claim Reviewer may deny the claim or may take an extension of time, and if the Reviewer takes an extension of time the extension notice will include a description of the missing information and shall specify a timeframe, no less than 45 days, in which the necessary information must be provided);

- **The date within which claimants may file an appeal of an adverse benefit determination under the plan's claims procedure** (the appeal of an adverse benefit decision must be filed within 180 days following the claimant's receipt of the notification of adverse benefit decision, except that the appeal of a decision to reduce or terminate an initially-approved course of treatment must be filed within 30 days of the claimant's receipt of the notification of the decision to reduce or terminate); and
- **The date within which claimants seeking medical or prescription drug benefits may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination** (a claimant must file a request for an external review with the Plan within 4 months after the date of receipt of a notice of an adverse benefit determination or final adverse benefit determination).

**ARTICLE X
LIMITATIONS ON FILING CLAIMS**

Legal Action. Except as required otherwise by applicable law, Participants must follow the Claims, Claims Appeal and External Claims Review Procedures prescribed under the Plan before taking action in any other forum regarding a Claim for benefits under the Plan. Any suit or legal action initiated by a Participant for benefits under the Plan must be brought no later than one year following a final decision on the Claim for benefits by the Plan Administrator or its delegate (including the decision on any appeal of the Claim), except to the extent any policy or contract of an Insurer provides a longer period of time to institute any suit or legal action. This limitation on suits for benefits shall apply in any forum where a Participant initiates such suit or legal action. Any claim or action not commenced within the above timeframes will be void and forfeited.

Examination. The Plan reserves the right to have a Participant examined by qualified medical personnel while any claim under the Plan is pending as often as the Plan may reasonably require.

Payment of Claims. All claim payments will be made directly to the provider (other than unapproved providers), unless the Employee gives the Plan or its agent written permission to reimburse the Employee and such written permission is included with the Employee's claim.

Legal Incapacity or Death. The Plan reserves the right to make payments directly to the spouse, parent, child, sibling, or legal guardian of the Participant if such person is a minor, or is, in the sole discretion of the Plan Administrator, legally incapable of giving valid receipt and discharge for any payment, or if amounts due the Participant remain unpaid at his death. Any payment made in this manner constitutes a complete discharge of the Plan's obligations to the extent of such payment.

Medical Authority. The Claims Administrator and/or its named agent, or where applicable, the Insurer, is the authorized agent of the Plan for determining Medical Necessity and determining Reasonable and Customary Charges, Fees and Expenses.

Overpayment. The Plan reserves the right to recover payments made to a Participant or his assignee in excess of the benefits payable under the Plan. The Plan also reserves the right to

withhold the amount of such excess payment from future benefits payable to the Participant or his assignee.

ARTICLE XI ADMINISTRATION

Administration. The Plan Administrator administers the Plan. The Plan Administrator has full discretion and authority to:⁷

- administer and interpret the Plan;
- determine eligibility for and the amount of benefits;
- determine the status and rights of participants, beneficiaries and other persons;
- make rulings and factual determinations;
- make regulations and prescribe procedures;
- gather needed information;
- prescribe forms;
- exercise all power and authority contemplated by ERISA and the Internal Revenue Code with respect to the Plan;
- employ or appoint persons to help or advise in any administrative functions, such as claims administrators, trustees or other service providers; and
- generally perform necessary functions to operate, manage and administer the Plan.

The Plan has other fiduciaries and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. The Plan has delegated to the insurance carriers and claims administrators listed above certain authority and responsibility for Plan administration, including processing claims.

Each fiduciary is solely responsible for its own acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. No fiduciary is liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary.

Except to the extent required by applicable law, the Plan Administrator's interpretation of this Plan shall be final and binding on all parties hereto.

The Plan Administrator may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Plan Administrator shall be uniformly and consistently applied to all Participants in similar circumstances. In making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished by the Participant, the Employer, the legal counsel of the Employer, or the Third Party Administrator.

Forms for Benefits. The Plan Administrator may require a Participant to complete and file with the Plan Administrator an application for a benefit and all other forms approved by the Plan

⁷ This includes the discretionary authority and control contemplated by the U.S. Supreme Court's decision in Firestone Tire & Rubber Co. v. Bruch.

Administrator, and to furnish all pertinent information requested by the Plan Administrator. The Plan Administrator may rely upon all such information so furnished it, including the Participant's current mailing address.

Indemnification of the Plan Administrator. The Plan Administrator and the individual members thereof shall be indemnified by the Employer against any and all liabilities arising by reason of any act or failure to act made in good faith pursuant to the provisions of the Plan, including expenses reasonably incurred in the defense of any claim relating thereto.

Named Fiduciary. The Named Fiduciary of the Plan is the Plan Administrator. Fiduciaries have the authority to control and manage the operation and administration of the Plan. Such fiduciaries may delegate such authority to the extent allowable by applicable law.

Exclusion of Payments for Services Performed by Particular Providers. The Plan Administrator or its delegate, or the Insurer in the case of Insured coverage, may, in its sole and absolute discretion, determine that a particular provider is not to be an approved provider under the Plan. In such event no services provided by such provider shall be paid by the Plan.

Changes in Coverage. The Employer reserves the right to amend the Plan in order to add or delete any Plan benefit, or otherwise change the terms of the Plan at any time, to the extent permitted by law, and consistent with the terms of any governing collective bargaining agreement. Except as otherwise required by applicable law, any increase in the amount of coverage under this Plan (because of a general coverage increase, or a change in a person's classification for benefit purposes) shall become effective on the effective date of such increase. Any decrease in coverage or deletion of a benefit takes effect on the effective date of the decrease or deletion for any Employee, Retiree, or Dependent, whether or not the Employee is an Active Employee, or a Retiree or Dependent is Hospital confined.

Action by the Employer. Any action by the Employer under this Plan may be by resolution by any person or persons duly authorized to take such action.

Structural Changes in Employer. In the event of the dissolution, merger, consolidation or reorganization of any Employer, provision may be made by which the Plan shall be continued by the successor, and, in that event, such successor shall be substituted for the Employer under the Plan. The substitution of the successor shall constitute an assumption of Plan liabilities by the successor, and the successor shall have all the powers, duties and responsibilities of such Employer under the Plan.

The Employer, by resolution of the Board of Trustees of UDM or the Plan Administrator, may terminate the Plan at any time. In the event of the dissolution, merger, consolidation or reorganization of UDM, the Plan shall automatically terminate, and the assets shall be liquidated unless the Plan is continued by a successor to UDM.

Governing Law. This Plan shall be administered, construed and enforced according to Michigan law, except to the extent preempted by ERISA.

**ARTICLE XII
MISCELLANEOUS**

Non-Guarantee of Employment. Nothing contained in this Plan shall be construed as a contract of employment between the Employer and any Employee, or as the right of any Employee to be continued in the employment of the Employer or as a limitation of the right of the Employer to discharge any of its Employees with or without cause.

Rights to Plan Assets. No Employee or Dependent shall have any right to, or interest in, any assets of the Plan upon termination of his employment or otherwise. All payments of benefits as provided for in this Plan shall be made solely out of the assets of the Employer or any trust established for such purpose, or in the case of any insured coverage, the assets of the Insurer, and none of the Plan fiduciaries shall be liable therefore in any manner.

Non-Alienation of Benefits. Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable hereunder shall be void. The Plan shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder. This provision does not apply to assignments of benefits to the provider of medical care upon which a claim is based, except that no assignment may be made to an unapproved provider.

Workers Compensation Not Affected. The Plan is not in lieu of, and does not affect any requirement for, coverage under workers compensation.

Conformity With Law. If any provision of the Plan is contrary to any law to which it is subject, such provision is automatically amended to conform thereto.

Failure to Enforce. Failure to enforce any provision of the Plan shall not affect the Employer's right thereafter to enforce such provision, nor shall such a failure affect its right to enforce any other provision of the Plan.

Verbal Statements. All statements made by the Employer, the Plan Administrator, or their officers, employees, and agents shall be deemed representations and statements of belief and opinion and are not warranties. No statements or other materials shall supersede the provisions of any insurance agreement governing the benefits described in the Benefit Booklets. In the event of any additions or inconsistencies found in any other documents, the additions or inconsistencies shall be void.

ARTICLE XIII ERISA RIGHTS

The University of Detroit Mercy Employee Benefits Plan has elected to have the Plan be subject to the Employee Retirement Income Security Act of 1974, as amended (“ERISA”) except to the extent expressly provided otherwise herein. As a participant in the University of Detroit Mercy Employee Benefits Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants will be entitled to:

Receive Information About the Plan and Benefits

- Examine, without charge, at the office of the Plan Administrator and at other specified locations, such as the personnel office, all documents governing the Plan, including insurance contracts, plan descriptions, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration of the U.S. Department of Labor.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary each year of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called “fiduciaries” of the Plan, have a duty to act prudently and in the interest of participants and beneficiaries. No one, including the Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit under the Plan or from exercising your rights under ERISA.

Enforce Your Rights

If your request for a benefit under the Plan is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to have your claim reviewed and reconsidered, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For example, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day (or such other amount in effect from time to time) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If your request for benefits is denied or ignored, in whole or in part, you may choose to file suit in a state or federal court.

If a Plan fiduciary misuses the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Director of Human Resources or the Benefits Coordinator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**ARTICLE XIV
ADMINISTRATIVE INFORMATION**

Plan Name

University of Detroit Mercy Employee Benefits Plan

Plan Number

501

Plan Sponsor, Plan Administrator and Named Fiduciary

University of Detroit Mercy
ATTN.: Benefits Manager, Human Resources Department
4001 McNichols Rd.
Detroit, MI 48221
(313) 993-1036
To access plan-related information and documents, go to:
<http://www.udmercy.edu/hr/benefits/index.htm>

Employer Identification Number

38-1360586

Agent for Service of Legal Process

University of Detroit Mercy
Director of Human Resources
4001 McNichols Rd.
Detroit, MI 48221
(313) 993-1036

Type of Plan

Employee welfare benefit plan with a Tax Code Section 125 cafeteria plan, providing medical/prescription drug benefits, dental benefits, vision benefits, basic life insurance coverage, accidental death and dismemberment coverage, voluntary life insurance coverage, long-term disability coverage, employee assistance program benefits, on-site dental clinic benefits, wellness program benefits, opt-out cash benefits, pre-tax premium benefits, dependent care flexible spending account benefits, and health flexible spending account benefits.

Plan Year

July 1 through the following June 30th.

Benefit Year

For the Health FSA, Dependent Care FSA, and post-65 Retiree medical benefits:
January 1 through the following December 31st.

For all other benefits: July 1 through the following June 30th.

Type of Administration

The Plan is administered by the Board of Administration and the Human Resources department, and the following insurance carriers (for insured benefits) and Claims Administrators (for self-insured benefits):

- *Cofinity Network Medical Benefits:*
CoreSource, Inc.
35601 Mound Road
Sterling Hts., MI 48310
(800) 831-1166
www.mycoresource.com
- *Pharmacy Benefit Manager:*
Navitus Health Solutions, LLC
P.O. Box 999
Appleton, WI 54912-0999
(855) 673-6504
www.navitus.com
- *Retiree Medicare Advantage Benefits:*
Aetna
Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
(800) 238-6716
www.aetna.com
- *Retiree Rx Benefits:*
Aetna Pharmacy Management
P.O. Box 52446
Phoenix, AZ 85072-2446
(888) 267-2637
www.aetnapharmacy.com
- *Telemedicine:*
Teladoc
(855)-Teladoc (835-2362)
www.Teladoc.com/mobile
- *STD Benefits:*
UNUM
P.O. Box 100158
Columbia, SC 29202-3158

(800) 858-6843
www.unum.com

- *Life and AD&D Insurance Benefits, and Voluntary Term Life and AD&D:*
UNUM
2211 Congress Street
Portland, Maine 04122
(866) 779-1054
www.unum.com
- *Dental Insurance*
UNUM/Starmount Life Insurance Company
8485 Goodwood Blvd.
Baton Rouge, LA 70806-7878
(888) 400-9309
DenteMax Plus/AlwaysCare In-network providers: unumdentalcare.com
- University of Detroit Mercy Dental Clinic
School of Dentistry -- Corktown Campus
2700 Martin Luther King Jr. Boulevard
Detroit, MI 48208-2576
(313) 494-6700
- *Vision Coverage:*
Heritage Vision Plans
440 E. Congress, Suite 300
Detroit, MI 48226
(800) 252-2053
Interactive Voice Response System: (800) 608-0410
www.heritagevisionplans.com
- *Flexible Spending Accounts:*
Employee Benefit Concepts, Inc.
a Group Resources® Company
P.O. Box 2365
Farmington Hills, MI 48333
(248) 855-8040
www.employeebenefitconcepts.com
<https://www.myflexonline.com/Login/Welcome.aspx>
- *COBRA Administrator:*
Employee Benefit Concepts, Inc.
a Group Resources® Company
P.O. Box 1358
Duluth, GA 30096
(800) 749-9963
www.employeebenefitconcepts.com
- *Pre-Tax Premiums and Opt-Out Cash:*
University of Detroit Mercy
Human Resources

4001 McNichols Rd.
Detroit, MI 48221
(313) 993-1036
<http://www.udmercy.edu/hr/benefits/index.htm>

Contributions and Funding

Plan benefits are paid by insurance carriers (for insured benefits) or by the Employer (for self-insured benefits). For self-insured benefits, payments will be made from the Employer's general assets unless the Employer establishes a trust or other fund for making benefit payments.

The Employer and covered individuals contribute towards the cost of Plan benefits through shared premium payments, co-payments, deductibles and as otherwise specified in the Plan, separate Benefit Booklets or as determined by the Employer. If you choose to enroll in the medical, prescription drug, or vision benefits, or several of the other benefits provided under the Plan, you will be required to pay an Employee contribution which for some benefits may be paid on a pre-tax basis. For any benefits for which you are required to pay an Employee contribution, you will be notified in advance of the contribution requirement, the contribution amount, and whether the Employee contribution will be made on a pre-tax or after-tax basis. The pre-determined Employee contribution amounts will be deducted from your paychecks.

Collective Bargaining Agreements

For some Employees, a collective bargaining agreement governs certain aspects of the benefits provided under the Plan. The Plan is intended to be interpreted consistent with the terms of those collective bargaining agreements.

NOTE: This document describes only the benefits available to the Employees and Retirees described in the "Eligibility" section on pages 10 and 11 of this document.

Effective July 1, 2022

Executed this _____ day of _____, 2022.

UNIVERSITY OF DETROIT MERCY

By: _____
Its: _____

General COBRA Notice

The following meets the Employer's obligation to provide an initial general COBRA Notice.

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an Employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the Spouse of an Employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

1. The end of employment or reduction of hours of employment;
2. Death of the Employee;
3. Commencement of a proceeding in bankruptcy with respect to the Employer;

4. The Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your Spouse.

Legally Domiciled Adults/Domestic Partners will not be eligible to elect COBRA continuation coverage. If the Employee elects COBRA continuation coverage, however, the Employee may continue coverage for a Legally Domiciled Adult/Domestic Partner. This non-COBRA continuation coverage will end when the Employee's coverage ends, and the Legally Domiciled Adult/Domestic Partner will not be entitled to extend coverage in the event the Employee dies or becomes entitled to Medicare.

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

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

When is COBRA continuation coverage available?

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

1. The end of employment or reduction of hours of employment;
2. Death of the Employee;
3. Commencement of a proceeding in bankruptcy with respect to the Employer; or
4. The Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Administrator.

How is COBRA continuation coverage provided?

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

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

beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must provide the Plan Administrator with your Social Security determination. *This coverage extension is not available for a Legally Domiciled Adult/Domestic Partner.*

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	COLORADO-Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	FLORIDA-Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268

<p align="center">GEORGIA-Medicaid</p> <p>A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2</p>	<p align="center">MAINE-Medicaid</p> <p>Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711</p> <p>Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711</p>
<p align="center">INDIANA-Medicaid</p> <p>Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584</p>	<p align="center">MASSACHUSETTS-Medicaid and CHIP</p> <p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840</p>
<p align="center">IOWA-Medicaid and CHIP (Hawki)</p> <p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562</p>	<p align="center">MINNESOTA-Medicaid</p> <p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p>
<p align="center">KANSAS-Medicaid</p> <p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884</p>	<p align="center">MISSOURI-Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p align="center">KENTUCKY-Medicaid</p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov</p> <p>KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718</p> <p>Kentucky Medicaid Website: https://chfs.ky.gov</p>	<p align="center">MONTANA-Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>
<p align="center">LOUISIANA-Medicaid</p> <p>Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p align="center">NEBRASKA-Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>

NEVADA-Medicaid	SOUTH CAROLINA-Medicaid
Medicaid Website: http://dhcftp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	SOUTH DAKOTA-Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	TEXAS-Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	UTAH-Medicaid and CHIP
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	VERMONT-Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	VIRGINIA-Medicaid and CHIP
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	WASHINGTON-Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	WEST VIRGINIA-Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA-Medicaid	WISCONSIN-Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	WYOMING-Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

NOTICE OF MARKETPLACE COVERAGE