

**Associated Universities, Inc.
Employee Welfare Benefit Plan**

Amended and Restated

Effective January 1, 2008

PREAMBLE AND EXECUTION

WHEREAS, Associated Universities Inc., a corporation organized under the laws of the State of New York, herein referred to as the "Employer," maintains the Associated Universities Inc. Employee Welfare Benefit Plan ("Plan"), ERISA Plan #502, which has been described in various contracts, agreements, and other documentation, as amended from time to time; and

WHEREAS, the Employer desires to continue to recognize the contribution made to the Employer by its Employees by rewarding those Employees who shall qualify hereunder and their dependents by providing various health and welfare benefits which shall become payable in the event of death, an accident or an illness; and

WHEREAS, the Employer is mindful of its obligation to operate the Plan in a manner consistent with applicable law and regulation; and

WHEREAS, the Employer desires to amend and restate the Plan in its entirety in a single governing instrument.

NOW, THEREFORE, by virtue and in exercise of the amending power reserved to the Employer and pursuant to the authority delegated to the undersigned officer of the Employer, the Plan is hereby amended and restated in its entirety, which shall be effective as of January 1, 2008.

IN WITNESS WHEREOF, the undersigned has caused the Plan to be executed by its duly authorized officer this 11 day of June, 2009.

Associated Universities Inc.

Signature: Cynthia L. Allen

Printed Name: Cynthia L. Allen

Title: AVI Controller

Associated Universities Inc. Employee Welfare Benefit Plan

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Associated Universities Inc. Employee Welfare Benefit Plan

ARTICLE I

ESTABLISHMENT OF PLAN

1.01 *Effective Date*

The Associated Universities Inc. Employee Welfare Benefit Plan (“Plan”) is amended and restated effective January 1, 2008. The Plan was first effective on December 15, 1947.

1.02 *Purpose*

The Plan has been created to provide specified health and welfare benefits to eligible Employees of the Employer and their Dependents. The Plan is intended to qualify under the applicable sections of the Internal Revenue Code of 1986, as amended or may be amended from time to time (“Code”), and is to be interpreted in a manner consistent with the applicable requirements of the Code. This document is intended to satisfy the applicable requirements of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). The benefits offered under this Plan may be the subject of a separate Insurance Policy, Administrative Services Agreement, benefit booklet, and/or benefit certificate. The provisions of any such Related Documents are incorporated herein by reference. Nothing in the Plan shall be construed as requiring compliance with Code or ERISA provisions that do not otherwise apply.

1.03 *Duration*

The Plan is to be maintained for the exclusive benefit of Employees and their eligible Dependents and is established with the intention of being maintained for an indefinite period of time; however, Associated Universities Inc., in its sole discretion and in accordance with the provisions of Article XII, may amend or terminate the Plan or any provision of the Plan at any time.

ARTICLE II

DEFINITIONS

The following words and phrases, when capitalized, shall have the following meanings unless a different meaning is plainly required by the context. Words and phrases not defined in this Article shall have the meaning set forth in the applicable Insurance Policy or Administrative Services Agreement, if any, and if not defined in the applicable Insurance Policy or Administrative Services Agreement, then such words and phrases shall have the meaning customarily given them by the applicable Insurer or third party administrator, as the case may be. Notwithstanding any provision to the contrary, words and phrases also defined in any applicable Related Document shall supersede this Article when used in interpreting that Related Document.

- 2.01** “*Actively at Work*” means the Employee is actually performing his normal duties if it is a scheduled workday. If the Employee is not at work due to a non-scheduled workday, holiday or vacation, Actively at Work means the Employee is capable of performing his normal duties. This definition applies to the Employee’s normal place of employment or to any other location where his duties require him to be.
- 2.02** “*Administrative Services Agreement*” means the written agreement and any attachments thereto, as amended, between the Employer or the Plan and a service provider, as needed to describe services to be provided by such provider. Such agreements are set forth in Appendix A and are hereby made a part of this Plan.
- 2.03** “*Affiliated Covered Entity*” means legally separate Covered Entities that are under common control or common ownership and are designated as an affiliated group of covered entities in accordance with 45 CFR §164.103. For purposes of this definition, “common control” exists if an entity has the power, directly or indirectly, significantly to influence or direct the actions or policies of another entity; and “common ownership” exists if an entity or entities possess an ownership or equity interest of five (5) percent or more of the other entity.
- 2.04** “*Affiliated Employer*” means any employer, as designated by the Employer, which is under common control with the Employer within the meaning of Code §414(b), (c), (m) and (o).
- 2.05** “*Benefit*” means any employee welfare benefit that is incorporated into this Plan and would be treated as an “employee welfare benefit plan” under Section 3(1) of ERISA if offered separately.

- 2.06** *“Benefit Plan”* means the specific terms and conditions regarding a Benefit that is provided by this Plan, including the terms and conditions of the Related Document(s), attached hereto as Appendix A, regarding such Benefit. The terms of such Benefit Plans, including but not limited to (as applicable) eligibility to participate, the amount payable, required deductibles, copayments, benefit maximums, conditions precedent to payment, limitations and exclusions, procedures for coordinating benefits payable, procedures for naming beneficiaries and consequences for failure to name a beneficiary, shall be as set forth in Appendix A. The Plan Sponsor may add a Benefit Plan or Related Document or delete a Benefit Plan or Related Document by amending Appendix A, without any need to otherwise amend this Plan. Amendment of Appendix A may be made by a duly authorized officer or representative of the Plan Sponsor.
- 2.07** *“CFR”* means the Code of Federal Regulations.
- 2.08** *“Claims Administrator”* means, with respect to any Benefit Plan, any individual(s) or entity(ies) that is(are) under a contract or agreement with the Plan Administrator to provide claim administration and related services. With respect to any insured Benefit Plan, the Insurer shall be the Claims Administrator.
- 2.09** *“COBRA”* means the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), as amended, and the regulations issued thereunder.
- 2.10** *“Code”* means the Internal Revenue Code of 1986, as hereto or hereafter amended or supplemented, or as superseded by laws of similar effect, together with the regulations and rulings issued pursuant thereto. Reference to any section or subsection of the Code includes references to any comparable or successor provisions of any legislation that amends, supplements or replaces such section or subsection.
- 2.11** *“Covered Entity”* means: (i) a Health Plan, (ii) Health Care Clearinghouse, or (iii) Health Care Provider who transmits any Health Information in electronic form in connection with a transaction covered by HIPAA, as defined more fully in 45 CFR §160.103. For purposes of Article VIII, a Covered Entity shall include the Health Care Components of the Plan.
- 2.12** *“Covered Expense”* means a charge for a service or supply allowable under the applicable Benefit Plan.
- 2.13** *“Covered Person”* means collectively Employees, Qualified Beneficiaries and Dependents who satisfy the requirements for coverage under the relevant Benefit Plan.

2.14 *“Dependent”* means, for purposes of this Plan, any person who meets the requirements as a dependent in accordance with the terms of the relevant Benefit Plan as set forth in the applicable Related Document. Unless otherwise specified, the term Dependent means:

- (a) The legally married Spouse of an Employee or Qualified Beneficiary and the common-law Spouse of an Employee or Qualified Beneficiary, if common-law marriage is recognized by the State in which the Employee or Qualified Beneficiary resides. Provided however, that no Spouse shall qualify as a Dependent if such individual is covered for benefits as an Employee.
- (b) An unmarried child (including any stepchild, legally adopted child, foster child or child placed for adoption) of an Employee or Qualified Beneficiary. Provided however, that no child shall qualify as a Dependent if such individual is covered for benefits as an Employee; nor if such individual is a member on active duty with the Armed Forces. Provided further that each child shall also meet one of the following:
 - (1) Less than nineteen (19) years of age and primarily dependent upon the Employee or Qualified Beneficiary for support and maintenance; or
 - (2) Dependent upon the Employee or Qualified Beneficiary for medical support pursuant to a valid Qualified Medical Child Support Order; or
 - (3) Less than twenty-five (25) years of age, if a full-time student and satisfactory proof of student status is submitted to the Plan Administrator. “Full-time student” means enrolled in a college or university and satisfying the institution’s requirements for full-time student status. For a proprietary school, such as business college, professional school or trade school, “full-time student” means a minimum of twenty-five (25) hours of classroom attendance per week; or
 - (4) Meets all of the following criteria:
 - (A) Unmarried and over the age of nineteen (19); and
 - (B) Dependent primarily on the Employee or Qualified Beneficiary for financial support and maintenance due to mental or physical handicap; and
 - (C) Incapable of self-sustaining employment; and
 - (D) Mental or physical handicap existed before the age of nineteen (19) and while covered under a medical benefits program offered by the Employer.

2.15 *“Effective Date”* means January 1, 2008, the amendment and restatement date of this Plan.

- 2.16** *“Employee”* means any common-law employee of the Employer who is regularly scheduled to work at least 20 hours per week and who satisfies the eligibility requirements of the applicable Related Document(s), attached hereto as Appendix A. However, an individual who is classified by the Employer as a temporary employee, leased employee or contract employee as defined under Code §401(c), shall not be an eligible Employee and therefore shall not be eligible to participate in the Plan regardless of whether, for employment tax or other purposes, the individual is subsequently determined not to be a leased employee, temporary employee or contract employee. For purposes of determining eligibility under the Plan, the classification to which an individual is assigned by the Employer shall be final and conclusive, regardless of whether a court or other entity subsequently finds that such individual should have been assigned to a different classification.
- 2.17** *“Employer”* means Associated Universities Inc. and any Participating Affiliate. For purposes of Article VIII, Employer shall also mean the Plan Sponsor.
- 2.18** *“ERISA”* means the Employee Retirement Income Security Act of 1974, Title 29 United States Code, as hereto or hereafter amended, and the regulations issued pursuant thereto. Reference to any section or subsection of ERISA includes references to any comparable or successor provisions of any legislation that amends, supplements or replaces such section or subsection.
- 2.19** *“FMLA”* means an Employee’s leave of absence granted by the Employer under the federal Family and Medical Leave Act of 1993.
- 2.20** *“Health Care”* means care, services, or supplies related to the health of an Individual within the meaning of 45 CFR §160.103. Health Care includes, but is not limited to, the following:
- (a) Preventative, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to physical or mental condition or functional status of an Individual or that affects the structure or function of the body; and
 - (b) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.
- 2.21** *“Health Care Clearinghouse”* has the meaning set forth in 45 CFR §160.103 and includes a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and “value-added” networks and switches, that performs either of the following functions:
- (a) Processes or facilitates the processing of Health Information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.

- (b) Receives a standard transaction from another entity and processes or facilitates the processing of Health Information into a nonstandard format or nonstandard data content for the receiving party.
- 2.22** *“Health Care Component”* means a component or combination of components of a Hybrid Entity that are designated by the Hybrid Entity in accordance with 45 CFR §164.105(a)(2)(iii)(C).
- 2.23** *“Health Care Operations”* shall have the meaning as set forth in Section 8.03 3(c) of the Plan.
- 2.24** *“Health Care Provider”* shall have the meaning set forth in 45 CFR §160.103 and includes a provider of medical or health services, as well as any other person or organization that furnishes, bills, or is paid for Health Care in the normal course of business.
- 2.25** *“Health Care Treatment”* shall have the meaning set forth in Section 8.03(a) of the Plan.
- 2.26** *“Health Information”* shall have the meaning set forth in 45 CFR §160.103 and includes information, whether oral or recorded in any form or medium, including, but not limited to, verbal conversations, telephonic communications, electronic mail or messaging over computer networks, the Internet and intranets, as well as written documentation, photocopies, facsimiles and electronic data, that is created or received by a Health Care Provider, Health Plan, an employer, life insurer, school or university, or Health Care Clearinghouse that relates to the past, present, or future physical or mental health or condition of an Individual, the provision of Health Care to an Individual, or the past, present, or future payment for the provision of Health Care to an Individual.
- 2.27** *“Health Plan”* means an individual or group plan that provides or pays the cost of medical care, and includes a group health insurance issuer and other such plans or arrangements as set forth in 45 CFR 160.103, including the Health Care Components of the Plan.
- 2.28** *“HIPAA”* means the Health Insurance Portability and Accountability Act of 1996, as hereto or hereafter amended, and the regulations issued pursuant thereto, including the HIPAA Privacy Rule.
- 2.29** *“HIPAA Privacy Rule”* means the regulation protecting the privacy of Individually Identifiable Health Information and applies to Health Care Providers, Health Plans, and Health Care Clearinghouses.

- 2.30** *“HMO”* means any health maintenance organization as defined in 45 CFR §160.103 or similar entity with a signed agreement with the Employer to provide certain health benefits to eligible Employees.
- 2.31** *“Hybrid Entity”* means a single legal entity that is a Covered Entity whose business activities include both covered functions and non-covered functions and that designates Health Care Components (in accordance with 45 CFR §164.105(a)(2)(iii)(C)) for purposes of fulfilling the hybrid entity requirements of HIPAA, as defined in 45 CFR §164.103. For purposes of this definition, “covered functions,” means those functions of a Covered Entity, the performance of which makes the entity a Health Plan, Health Care Provider, or Health Care Clearinghouse.
- 2.32** *“Individual”*, as such term is used in Article VIII, has the meaning set forth in 45 CFR §164.502 as the person who is the subject of Protected Health Information.
- 2.33** *“Individually Identifiable Health Information”* has the meaning set forth in 45 CFR §160.103 and includes Health Information, including demographic information, collected from an Individual and created or received by a Health Care Provider, Health Plan, employer, or Health Care Clearinghouse that identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual involved.
- 2.34** *“Insurance Policy”* means the written agreement, as amended, between the Employer and an Insurer, which provides for a transfer of the risk associated with the provision of Benefits under one or more of the Benefit Plans from the Employer to the Insurer. Any Insurance Policy shall be effective in accordance with the terms of such policy. Such insurance policies are set forth in Appendix A and are hereby made part of this Plan.
- 2.35** *“Insurer”* means an insurance company or HMO with a signed contract with the Employer to provide coverage under one or more of the Benefit Plans.
- 2.36** *“Late Enrollee”* means an eligible Employee or Dependent who has declined enrollment in a Health Plan at the time of the initial enrollment period, and who subsequently requests enrollment in the Plan. However, an eligible Employee or Dependent shall not be considered a Late Enrollee if the eligible Employee or Dependent meets all of the following requirements:
- (a) He was covered under another employer health benefit plan at the time he was initially eligible to enroll, or was not covered under another health plan when initially eligible to enroll but, after subsequently acquiring coverage under another health plan, had opted not to enroll in the Plan at a subsequent open enrollment opportunity; and
 - (b) To the extent required by and in the manner specified by the Employer, he certified at the time of eligibility for enrollment in the Plan that coverage

under another health benefit plan was the reason for declining enrollment in the Plan provided that, if he was covered under another health plan, he was given the opportunity to make the certification required and was notified that failure to do so could result in later treatment as a Late Enrollee; and

- (c) He has lost or will lose coverage under another employer health benefit plan as a result of: (i) his termination of employment or as a result of the termination of employment of individual through whom he was covered as a dependent, (ii) a change in his employment status or of the employment status of the individual through whom he was covered as a dependent, (iii) the termination of the other plan's coverage, (iv) the cessation of an employer's contribution toward such coverage, (v) the death of the individual through whom he was covered as dependent, or (vi) his divorce; and
- (d) He requests enrollment in the Plan within thirty (30) days following the termination of coverage or the cessation of the employer's contribution toward such coverage provided under another employer health benefit plan.

2.37 *“Military Leave”* means an Employee’s leave of absence granted by the Employer consistent with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994.

2.38 *“Organized Health Care Arrangement”* has the meaning set forth in 45 CFR §160.103 and includes:

- (a) A group health plan (within the meaning of 45 CFR §160.103) and a health insurance issuer or HMO with respect to such group health plan, but only with respect to Protected Health Information created or received by such health insurance issuer or HMO that relates to Individuals who are or who have been participants or beneficiaries in such group health plan;
- (b) A group health plan and one (1) or more other group health plans each of which are maintained by the same Plan Sponsor; or
- (c) The group health plans described in paragraph (b) of this definition and health insurance issuers or HMOs with respect to such other group health plans, but only with respect to Protected Health Information created or received by such health insurance issuers or HMOs that relates to Individuals who are or have been participants or beneficiaries in any of such group health plans.

- 2.39** *“Other Group Health Plan”* means a group benefit plan, other than those provided under this Plan that provides medical coverage on an insured or uninsured basis. Other Group Health Plan includes, but is not limited to, any group, blanket, or franchise insurance, group practice or prepaid coverage plans, labor-management trusteed plans, union welfare plans, employer organization plans, group automobile insurance, individual automobile insurance based on the principles of “no fault” coverage, group coverage sponsored by or provided through a school, university or other educational institution, coverage under any governmental program, and coverage required or provided by law.
- 2.40** *“Participant”* means an Employee or Qualified Beneficiary who meets the requirements for participation set forth in Article III and, relative to a particular Benefit, the Related Documents attached hereto, and who elects to become a Participant and has not for any reason become ineligible to participate further in the Plan.
- 2.41** *“Participating Affiliate”* means any Affiliated Employer that adopts this Plan and makes contributions as required by the Employer.
- 2.42** *“Plan”* means the “Associated Universities Inc. Employee Welfare Benefit Plan”.
- 2.43** *“Plan Administrator”* means the individual(s) or corporation(s) appointed by the Employer to carry out the administration of the Plan. In the event the Plan Administrator has not been appointed, or resigns from a prior appointment, the Employer shall be deemed to be the Plan Administrator.
- 2.44** *“Plan Sponsor”* means the entity defined in §3(16)(B) of ERISA, 29 U.S.C. §1002(16)(B).
- 2.45** *“Plan Year”* means the period from January 1st through December 31st, and the 12-month period beginning each January 1st thereafter. For employees hired during a Plan Year, the initial coverage period shall be that portion of the Plan Year commencing on such Participant’s date of entry into the Plan and ending on the last day of such Plan Year.
- 2.46** *“Policy”* means any formal set of Employer practices and/or rules that have been adopted and approved by the appropriate representatives of the Employer.
- 2.47** *“Privacy Notice”* means the statement communicated to Plan Participants that sets forth the uses and disclosures of Protected Health Information that may be made by the Plan under HIPAA, as more fully described in 45 CFR §164.520.

- 2.48** ***“Privacy Official”*** means the Individual appointed by the Employer, as may be required and appropriate, on behalf of a Health Care Component of the Plan, who is responsible for developing and implementing policies and procedures for protecting the privacy and confidentiality of Protected Health Information that is held by or on behalf of the Employer’s Health Plans
- 2.49** ***“Protected Health Information” (“PHI”)*** means Individually Identifiable Health Information created or received by a health plan, employer, health care provider or health care clearinghouse that relates to (a) the past, present or future physical or mental health or condition of an individual, (b) the provision of health care to an individual, or (c) the past, present, or future payment for the provision of health care to an individual. Protected Health Information includes information that is transmitted by electronic media, maintained in electronic media, transmitted or maintained in any other form or medium, including oral or written information. Protected Health Information excludes Individually Identifiable Health Information in education records covered by the Family Educational Rights and Privacy Act, as amended (within the meaning of 20 U.S.C. 1232g), employment records held by the Employer in its role as an employer, and other records described in 20 U.S.C. 1232g(a)(4)(B)(iv).
- 2.50** ***“Qualified Beneficiary”*** means any person afforded rights of continued group health care coverage under COBRA as a result of a qualifying event, as defined in Section 9.12(g) of Article IX.
- 2.51** ***“Qualified Medical Child Support Order” (“QMCSO”)*** means a court or administrative order requiring the Plan to provide medical coverage to an otherwise eligible child.
- 2.52** ***“Related Document”*** means the applicable documents, including Insurance Policies, Administrative Services Agreements, benefit booklets, or certificates of insurance, listed in Appendix A, which are hereby incorporated in the Plan by reference.
- 2.53** ***“Required by Law”*** means a mandate contained in law that compels an entity to make a use or disclosure of Protected Health Information and that is enforceable in a court of law including, but not limited to, a court order, a court-ordered warrant, subpoena, or summons issued by a court, grand jury, a governmental or inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to Health Care Providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits, as more fully described in 45 CFR §160.103.

2.54 **“Summary Health Information”** has the meaning set forth in 45 CFR §164.504 and includes information that summarizes the claims history, expenses, or types of claims by Individuals for whom the Plan Sponsor has provided benefits under the Plan, and from which the following information has been removed:

- (a) Names;
- (b) Geographical subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code (if permitted under 45 CFR §164.514(b)(2)(i)(B));
- (c) All elements of dates (except year) directly relating to the Individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission or discharge date) except that ages and elements may be aggregated into a single category of ages over age 89);
- (d) Other identifying numbers, such as Social Security, telephone, fax, account or medical record numbers, e-mail or Internet addresses, URLs or Internal Protocol (IP) address numbers, vehicle identifiers and serial numbers;
- (e) Facial photographs or biometric identifiers (e.g., finger prints);
- (f) Any other unique identifying number, characteristic, or code; and
- (g) Any information of which the Employer has knowledge that could be used alone or in combination with other information to identify an Individual.

2.55 **“Spouse”** means the person who is legally married to the Employee or Qualified Beneficiary under the laws of the state in which they reside. Notwithstanding the foregoing, for purposes of the Health Care Reimbursement Account and the Dependent Care Reimbursement Account under the Associated Universities, Inc. Flexible Spending Account Plan, “Spouse” does not include a same-sex spouse.

2.56 **“Termination”** means the termination of a Participant’s employment as an Employee of the Employer, whether by reason of change in job classification, discharge, voluntary termination, disability, retirement, or death.

2.57 **“USC”** means the United States Code.

ARTICLE III

ELIGIBILITY AND PARTICIPATION

3.01 *Eligible Employees*

All Employees (as defined in Section 2.16) are eligible to participate in the Plan, except as otherwise provided with respect to a particular Benefit in the applicable Related Document.

3.02 *Participation*

- (a) An eligible Employee's need to satisfy a specified period of service prior to participation in a specific Benefit provided under the Plan is as set forth in the applicable Related Document, attached hereto as Appendix A, the provisions of which are incorporated by reference.
- (b) An Employee who has met the eligibility condition and any applicable service-waiting period as provided in Section 3.01 and 3.02(a) (an "Eligible Employee) shall be automatically enrolled in the Life and Accidental Death and Disability Benefit program and the Business Travel Accident Benefit program hereunder as soon as administratively practical after meeting such requirements. An Eligible Employee may elect to purchase supplemental life insurance and accidental death and disability insurance through after-tax contributions.
- (c) An Eligible Employee who has reached the age of 30 shall be automatically enrolled in the Long Term Disability Benefit program as soon as administratively practical after meeting such requirements. An Eligible Employee who has not yet reached age of 30 may choose to enroll in the Long Term Disability Benefit program by completing such enrollment forms at the time and in the manner prescribed by the Plan Administrator. In either case, the cost of Employer's share of such coverage (as determined by the Employer) shall be deducted from such Eligible Employee's compensation on an after-tax basis.
- (d) A Participant may enroll in the Dental Benefit program, the Premium Payment program, the Health Care Reimbursement Account, and the Care Reimbursement Account, and may change such enrollment, only in accordance with the terms and conditions set forth in the Associated Universities Inc. Flexible Spending Account Plan.
- (e) An Employee who fails to take the necessary steps to participate in the Plan as established by the Plan Administrator shall be able to participate in a future Plan Year, provided he enrolls and makes the required election prior to the beginning of such future Plan Year, within the time and in the manner determined by the Plan Administrator.

3.03 Termination of Participation

- (a) Except to the extent this Plan or the applicable Related Documents provide otherwise, each Participant's eligibility to participate in this Plan and his coverage under this Plan shall terminate upon the occurrence of any of the following events:
- (1) He ceases to satisfy the eligibility conditions specified within this Plan and the applicable Related Document(s);
 - (2) His Termination;
 - (3) His death; or
 - (4) The termination of this Plan.
- (b) If participation in the Plan ceases due to Termination (other than by reason of such Employee's gross misconduct) or by reason of a change of employee status such that eligibility to participate in a Health Care Component of the Plan is lost, such participation may be continued as set forth in Article IX hereof.

3.04 Participation Following Termination

Following Termination, a rehired Employee's subsequent participation in this Plan shall occur at the time and in the manner consistent with applicable federal statutes and as set forth within the provisions of this Plan and Related Documents, just as if such Employee were a new Employee of the Employer.

3.05 Coverage During Personal Leave

If an Employee is on a personal leave of absence, which has been requested and approved in a manner consistent with the Policies of the Employer, Benefits under this Plan will continue during the period of such personal leave of absence in the same manner as if such Employee were Actively at Work, to the extent permitted under the applicable Benefit Plan and Related Documents, as well as the Employer's leave of absence Policies. For purposes of this section, a personal leave of absence shall mean an approved absence from work (such as a sabbatical for tenured scientists), which does not qualify as FMLA or Military Leave.

ARTICLE IV

OTHER BENEFIT COVERAGE

4.01 *Benefit Limitations*

Benefits provided under any Benefit Plan may be limited by benefits received by a Covered Person from other sources. Such sources may include benefits payable under Workers' Compensation, Social Security, Medicare or other government-sponsored programs. Such sources may also include benefits from other insurance policies, plans or programs, including those sponsored by a Covered Person's own employer.

4.02 *Health Plan Coordination of Benefits*

Absent any provision in a Related Document to the contrary, Benefits payable for Covered Expenses of a Covered Person who also is entitled to benefits from an Other Group Health Plan shall be coordinated so that the total amount payable shall not exceed the amount of the Covered Expense, as set forth in each Health Plan.

- (a) When an Other Group Health Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a paid benefit.
- (b) If this Plan is secondary to a managed network health program such as an HMO; payable Plan benefits are limited to the copayments due under the managed care network. Benefits provided under this Plan will not coordinate with benefits provided under any other managed network health program or HMO.
- (c) Any expense not payable by a primary plan due to the individual's failure to comply with any utilization review requirements will not be considered an allowable expense.
- (d) If the Other Group Health Plan does not contain a coordination of benefits provision, the Other Group Health Plan shall be primary and this Plan shall be secondary.

- (e) If the Other Group Health Plan does contain a coordination of benefits provision, similar to this one, this Plan will determine its benefits using the guidelines set forth herein. If in accordance with the rules of this Article IV, this Plan is to pay benefits before an Other Group Health Plan, this Plan will pay its normal liability without regard to benefits of the Other Group Health Plan. If this Plan is to pay its benefits after an Other Group Health Plan, this Plan will pay its normal liability less any benefits paid by the other plan. The combined coverage shall not be more than this Plan would normally pay.
- (f) Benefits payable under an Other Group Health Plan include such amounts as would have been payable had a claim been properly filed for them.
- (g) The rules establishing the order of benefit determination are:
 - (1) The benefits of the plan, which covers a person as an active employee, shall be paid first.
 - (2) The benefits of a plan which covers a person as the dependent of an active employee shall be paid before those of a plan which covers the person as an inactive employee or retiree or as such person's dependent.
 - (3) If the claimant is a dependent child and such child's parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the other parent. However, if both parents have the same birthday, the benefits of the plan, which covered the parent longer, are determined first.
 - (4) If the claimant is a dependent child and such child's parents are separated or divorced:
 - (A) The benefits of the plan, which covers the claimant as a dependent child of the parent with custody, shall be determined first.
 - (B) The plan of the spouse of the parent with custody will be determined second.
 - (C) The plan of the parent not having custody of the child will be determined third.

Provided however, that if a court decree assigns financial responsibility for the health care expenses of the dependent child to one of the parents, the benefits of the assigned-parent's plan will be determined first.

- (5) If the other plan does not have rules similar to those described above, and if as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.
- (6) If none of the above rules establish an order of benefit determination, the benefits of the plan, which has covered the claimant for the longer period of time, will be determined first.
- (h) When the rules of this Article IV operate to reduce the total amount of benefits otherwise payable to a Covered Person under this Plan during any claim determination period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of a Health Plan.

4.03 *Special Medicare Rules*

An active regular employee age 65 or older will continue to be eligible for this Plan and Medicare, if elected, would be secondary.

Except as otherwise prohibited by federal law, any otherwise Covered Person who is also entitled to benefits under the Medicare program may elect or reject medical coverage under this Plan.

This Plan will pay benefits primary to Medicare only when required to do so by law. In all other instances, this Plan will pay secondary to Medicare.

4.04 *Subrogation and Reimbursement*

Except as otherwise indicated in a Related Document, the Plan shall have the option of becoming subrogated to all claims, causes of action and other rights which the Covered Person (or his estate, parent or guardian) may have against a third party or insurer, government program, or other source of coverage for monetary damages, compensation or indemnification on account of any illness or injury allegedly caused by a third party.

- (a) The Plan and the Employer shall have the following rights:
 - (1) To pursue a Covered Person's legal claims or rights against another party, or any insurance company, when Plan benefits are paid or provided to a Covered Person and the condition, illness or injury for which the benefits were paid either were caused by the other party or are covered by other insurance.
 - (2) To pursue a Covered Person's legal rights against any other party or under any insurance coverage with respect to any injury, illness or condition for which this Plan has provided benefits.

- (3) To be reimbursed from any damage award or insurance proceeds by the Covered Person and his legal representatives, estate and heirs for the full value of any benefits provided in relation to an injury, illness or other condition which is caused by the other party or is covered by other insurance.
- (b) Subrogation applies whenever another person or insurance carrier is, or may be considered, liable for damages or pays insurance proceeds with respect to a Covered Person's injury, illness or condition, and this Plan has provided or paid benefits (or is legally required to pay) with respect to such injury, illness or condition.

By accepting coverage or benefits under the Plan, the Covered Person agrees that, to the extent of the full value of any such benefits paid or provided by the Plan, the Plan and the Employer are subrogated to all rights of the Covered Person against any third party or insurance company.

By accepting coverage or benefits under this Plan, the Covered Person:

- (1) Agrees that the Plan and the Employer may assert their subrogation rights independent of the Covered Person.
- (2) Agrees and is obligated to cooperate with the Plan and its agents to pursue and protect the Plan's and the Employer's subrogation rights. Among other things, the Covered Person shall provide the Plan with any relevant information requested and shall sign and deliver any documents requested by the Plan.
- (3) Agrees that the Plan's and the Employer's rights of subrogation shall be considered as a first priority claim against any other person or entity, to be paid before any claims are paid, including claims by the Covered Person for general damages.
- (4) Agrees that he will not release any party from liability for the payment of medical expenses without first obtaining the written consent of the Plan.
- (5) Agrees that, if he enters into litigation or settlement negotiations regarding the obligations of or claims against other parties, he will notify the Plan and will not prejudice in any way the Plan's and the Employer's subrogation rights.
- (6) Agrees that the Plan and/or the Employer or their agents may take any lawful action to pursue and protect the Plan's and the Employer's subrogation rights.

- (7) Agrees that the costs of legal representation of the Plan and the Employer in matters related to subrogation shall be borne solely by the Plan and the Employer, and that the costs of the Covered Person's legal representation shall be borne solely by the Covered Person, unless there is a written agreement to the contrary. That is, unless the Plan and the Employer agree otherwise in writing, the Plan's and the Employer's rights to recover the full value of benefits paid or provided to the Covered Person shall in no way be diminished by the cost of legal representation of the Covered Person.
- (c) Reimbursement applies whenever a Covered Person recovers damages or insurance proceeds by settlement, verdict or otherwise for or in relation to an injury, illness or other condition and the Plan and/or the Employer has paid or provided benefits in relation to such injury, illness or other condition.

By accepting coverage or benefits under the Plan, the Covered Person:

- (1) Agrees on behalf of himself and his legal representatives, estate and heirs, that the Plan and/or the Employer shall be reimbursed promptly from any settlement, verdict, insurance proceeds or other recovery, the full value of the benefits paid or provided by the Plan.
- (2) Agrees that the Plan or the Employer, at their option, may collect amounts from the proceeds of any settlement, verdict, judgment, insurance coverage or other recovery by the Covered Person or his legal representative, regardless of whether the Covered Person has been fully compensated.
- (3) Grants the Plan and the Employer a first priority lien, to the extent of the Plan's and the Employer's claim for reimbursement, against the proceeds of any such settlement, verdict, insurance proceeds or other recoveries or amounts received by or on behalf of the Covered Person or his legal representatives, estate or heirs.
- (4) Assigns to the Plan and the Employer any benefits the Covered Person may have or be entitled to under any automobile policy or any other coverage, to the extent of the Plan's and the Employer's claim for reimbursement.
- (5) Agrees to sign and deliver, at the request of the Plan, any documents that are needed to protect such lien or effect such assignment of benefits.
- (6) Agrees to cooperate with the Plan and its agents, to provide any requested information, and to take such actions as the Plan or its agents request, all to protect the right of reimbursement of the Plan and the Employer and to assist the Plan and/or the Employer in making a full recovery of the value of the benefits paid or provided.

- (7) Agrees to take no action that would prejudice the Plan's and the Employer's rights of reimbursement.
- (8) Agrees that the Plan and the Employer shall be responsible only for those legal fees and expenses to which they agree in writing.
- (9) Agrees to hold any proceeds of any settlement, verdict, judgment, insurance coverage or other recovery in trust for the benefit of the Plan and the Employer and that the Plan and the Employer shall be entitled to recover from the Covered Person reasonable attorney fees incurred in collecting such proceeds from the Covered Person.

ARTICLE V

CONTRIBUTIONS AND FUNDING

5.01 *Contributions*

As a prerequisite to Participation, each Employee may be required to contribute toward the cost of the Benefits provided under a Benefit Plan. The amount of any such contribution shall be determined from time to time by the Employer. As soon as reasonably practical after each payroll period, the Employer shall apply Employee contributions to the payment of any costs associated under the Plan.

5.02 *No Obligation to Insure or Fund Benefits*

The Employer shall have no obligation, but shall have the right, to insure any Benefits under the Plan or to establish any fund or trust for the payment of Benefits under this Plan except as mandated by law.

5.03 *Insured Benefits*

In the case of a Benefit that is insured with an insurance company, any Benefits accruing shall be paid solely by such insurance company, and the Employer shall have no responsibility for the payment of such Benefits.

5.04 *Non-Insured Benefits*

Payments of any non-insured and/or un-funded Benefits under the Plan shall be made solely out of the general assets of the Employer.

5.05 *Payment of Plan Expenses*

All expenses of the Plan shall be paid by the Plan to the extent they are not paid for by the Employer. The Employer may be reimbursed by the Plan for any expenses it may pay for on behalf of the Plan, to the maximum extent permitted by law and the Plan.

ARTICLE VI

ADMINISTRATION

6.01 Plan Administrator

The administration of the Plan shall be under the supervision of the Employer, as Plan Administrator. It shall be a principal duty of the Plan Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan.

6.02 General Fiduciary Responsibilities

The Plan Administrator and any other fiduciary under ERISA shall discharge their duties with respect to this Plan solely in the interest of the Participants and their beneficiaries and:

- (a) For the exclusive purpose of providing Benefits to Participants and their beneficiaries;
- (b) With the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and
- (c) In accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

6.03 Specific Responsibilities and Authority of the Plan Administrator

Other than to the extent assigned under the terms of a Related Document, the Plan Administrator shall have such duties and powers as may be necessary to administer this Plan, including, but not by way of limitation, the following.

- (a) To construe and interpret the Plan, and decide all questions of eligibility.
- (b) To prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan.
- (c) To prepare and distribute information explaining the Plan to Participants.
- (d) To receive from Participants such information as shall be necessary for the proper administration of the Plan.
- (e) To furnish the Participants such annual reports with respect to the administration of the Plan as are reasonable and appropriate, or as may be required by law.
- (f) To appoint individuals to assist in the administration of the Plan and to engage any other agents it deems advisable, including legal and employee benefit consulting firm counsel.

- (g) To purchase any insurance deemed necessary for providing Benefits under this Plan.
- (h) To promulgate election and claim forms to be used by Participants.
- (i) To prepare and file any reports or returns with respect to the Plan required by the Internal Revenue laws or any other laws.
- (j) To recommend to the Employer such amendments in the Plan as it deems necessary or appropriate in order to enable the Plan to comply with ERISA and any other applicable legal requirements, and
- (k) To take all actions not expressly enumerated herein necessary for effective administration of the Plan.

In exercising their fiduciary functions, the Plan fiduciaries have the duty and full discretionary authority to determine eligibility for benefits and to interpret and apply the terms of the Plan, including making any factual determinations. Using their discretionary authority, the Plan fiduciaries may correct defects, rectify any omission, or reconcile any inconsistency or ambiguity in the Plan. No decision by the Plan fiduciaries shall be set aside by a court, unless the party contesting the decision shall prove by clear and convincing evidence that the decision is arbitrary and capricious.

6.04 *Insurer / Claims Administrator Responsibilities*

- (a) The Plan shall be administered by the applicable Insurer and /or Claims Administrator in accordance with the terms and conditions of the applicable Related Document.
- (b) The applicable Insurer and/or Claims Administrator shall be a “named fiduciary” for purposes of ERISA with respect to the portions of the Plan that are governed by the applicable Related Document and to the extent provided in such Related Document.

6.05 *Delegation of Authority*

The Plan Administrator has the discretion to delegate to any other person or persons (including, but not limited to, the applicable Insurer and/or Claims Administrator) authority to act on behalf of the Plan Administrator, including, but not limited to, the authority to make any Benefits determination, or to sign checks or other instruments incidental to the operation of the Plan, for which the Plan Administrator would otherwise be responsible.

6.06 *Rules and Decisions*

The Plan Administrator may adopt such rules and procedures, as it deems necessary, desirable, or appropriate. When making any decision or determination, the Plan Administrator shall be entitled to rely upon such information as may be furnished to it by a Participant, legal counsel, or the contracted insurance company or benefits administrator under the Plan.

6.07 *Indemnification*

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any director, officer, Employee, or agent of the Employer against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) (collectively "Loss") occasioned by any act or omission to act that constitutes or is alleged to constitute a breach of such person's responsibilities in connection with the Plan under ERISA or any other law, unless such Loss is determined to be due to such person's gross negligence or willful misconduct.

6.08 *Reliance on Other Information*

In administering the Plan, the Plan Administrator will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the insurers or administrators of any of the Benefit Plans offered within the Plan, or by accountants, counsel or other experts employed or engaged by the Plan Administrator.

6.09 *Standard of Review*

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole and exclusive discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall interpret all Plan provisions, and make all determinations as to whether any particular Participant or beneficiary is entitled to receive any benefit under the terms of this Plan, which interpretation shall be made by the Plan Administrator in its sole and exclusive discretion.

If, due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by consistent interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive discretion, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator in its sole discretion in accordance with Section 6.03. The Plan shall be amended retroactively to cure any such ambiguity. Neither this Section 6.03, nor any other Plan provision, may be invoked by any person to require the Plan to be interpreted in a manner that is inconsistent with its interpretation by the Plan Administrator. Any construction of the terms of the Plan that is adopted by the Plan Administrator and for which there is a rational basis shall be final and legally binding on all parties.

Any interpretation of the Plan or other action of the Plan Administrator shall be subject to review only if such interpretation or other action is without rational basis. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review and shall be entitled to the maximum deference permitted by law.

ARTICLE VII

CLAIMS PROCEDURES

7.01 *Claim Filing Procedures*

Claims with respect to a Benefit Plan shall be submitted directly to the Claims Administrator, as designated in the applicable Benefit Plan and/or Related Document, on such forms as are prescribed by the Claims Administrator. The claimant may be required to provide such other information as the Claims Administrator may deem necessary or appropriate for determining the validity of any claim.

7.02 *Payment of Claims*

Upon submission of proof of a valid claim, any benefits shall be paid to the Participant or beneficiary in accordance with all relevant provisions of the applicable Benefit Plan. If the Plan Administrator (or its representative) shall determine that a Participant has not incurred a Covered Expense or that the benefit is not covered under the Plan, or if the Participant shall fail to furnish such proof as is requested, no benefits hereunder shall be payable to such Participant.

7.03 *Claims Procedures*

Any claim by a Participant for Benefits under the Plan shall be governed by the terms of the Plan and any applicable Related Document. The Plan Administrator (or its representative) will be responsible for making all determinations as to the rights of any Participant or any beneficiary of a Participant to receive Benefits under the Plan, to the extent the Related Document does not give such authority to (or such authority has not been delegated to) the Claims Administrator.

If a claim is not governed by the terms of a Related Document, or if the applicable Related Document does not set forth claims procedures with respect to such Benefit, then the claims procedure described in Section 7.04 shall govern. To the extent that a Benefit program is not an employee welfare benefit plan under Section 3(1) of ERISA, such as the Premium Payment Program or Dependent Care Reimbursement Account, the claims procedures set forth in this Article VII shall apply only to the extent that the Plan Administrator so determines.

7.04 Claim Denial and Appeal

The following procedures apply only to the extent a claim is not subject to procedures set forth in the applicable Related Document. Any person who believes that he or she is then entitled to receive a Benefit under the Plan, including one greater than that initially determined by the Claims Administrator or other authorized entity, may file a claim in writing with the Plan Administrator. References to the Plan Administrator hereunder will be deemed to apply to the Claims Administrator to the extent that the Plan Administrator has delegated responsibility for review of the claim to such Claims Administrator by insurance contract or otherwise.

- (a) **Review of Claims.** Except as provided with respect to group health plan claims under paragraph (f) below, the Plan Administrator shall, within ninety (90) days of the receipt of a claim, either allow or deny the claim in writing. For disability coverage claims, the Plan Administrator shall, within forty-five (45) days of the receipt of a claim, subject to extension as described below, either allow or deny the claim in writing. A denial of a claim shall be written in a manner calculated to be understood by the claimant and shall include (a) the specific reason or reasons for the denial; (b) specific references to pertinent Plan provisions on which the denial is based; (c) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and (d) an explanation of the Plan's claim review procedure.

In addition, for group health plan claims and long-term disability claims, such notice of denial of a claim shall include:

- (1) any specific rule, guideline or protocol that was relied upon, or a statement that such rule, guideline or protocol was relied upon and that the claimant may request a copy of such rule, guideline or protocol free of charge;
- (2) if the denial of a claim is based on a medical necessity or experimental treatment exclusion, an explanation of the scientific or clinical judgment, or a statement that the claimant may request such explanation free of charge; and
- (3) in the case of an urgent care claim (as defined in Section 7.04(f)(1)(ii)), a description of the expedited review process.

- (b) Access to Documents. A claimant may request and receive reasonable access to and copies of relevant documents, records and other information in the Company's possession free of charge. Relevant documents records and other information are those that (a) were relied on in making the benefit determination; (b) were submitted, considered, or generated in the course of making the benefit determination; (c) demonstrate compliance with the Plan's or Benefit program's administrative processes or safeguards; or (d) in the case of disability or group health plan claims, constitute a statement of the Plan's or Benefit program's policy or guideline regarding the benefit for the claimant's diagnosis, whether or not relied upon.
- (c) Appeal of Claim Denial. A claimant (or his or her duly authorized representative) whose claim is denied may, within sixty (60) days (one hundred eighty (180) days for disability coverage claims), or within such other times for group health plan claims as are set forth in Section 7.04(f) after receipt of denial of the claim (a) submit a written request for review to the Plan Administrator; (b) review relevant documents (as defined in Department of Labor regulations); and (c) submit issues and comments in writing.
- (d) Review of Appeal of Claim Denial. The Plan Administrator shall notify the claimant of its decision on review within sixty (60) days of receipt of a request for review. In the case of a disability coverage claim the Plan Administrator shall notify the claimant of its final determination within forty-five (45) days, subject to extension as described below, of the receipt of a request for review or appeal. In the case of a group health plan claim, the Plan Administrator shall notify the claimant within the applicable period as set forth in Section 7.04(f). The decision on review shall be written in a manner calculated to be understood by the claimant and shall include specific reasons for the decision and specific references to the pertinent Plan provisions on which the decision is based. In addition, the following rules shall apply to the review of a claim denial relating to a long-term disability or group health Benefit program:
 - (1) The review of the claim must be performed by someone who is neither the original decision maker nor the subordinate of the original decision maker. In reviewing the initial decision, the decision maker may not give deference to the initial decision, and he or she must consider all information relevant to the claim, regardless of whether such information was relied upon or available when the original decision was made. The decision maker must also consider any information submitted by the claimant.

- (2) If denial of the disability coverage claim or group health plan claim was based on a medical judgment, including whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary of the Plan reviewing the claim shall consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. Medical or vocational experts whose advice was obtained on the Plan's behalf in connection with denial of a disability coverage claim shall be identified for the claimant. If a health care professional is engaged for purposes of consultation in deciding an appeal of denial of a disability coverage claim, such professional shall not be the same individual (or the subordinate of such individual) who was consulted in the initial denial of the claim.
- (e) Extension of Review Period. The 90-day and 60-day periods described in Sections 7.04(a) and 7.04(c), respectively, may be extended at the discretion of the Plan Administrator for a second 90- or 60-day period, as the case may be, provided that written notice of the extension is furnished to the claimant prior to the termination of the initial period, indicating the special circumstances requiring such extension of time and the date by which a final decision is expected.

The 45-day period described in Sections 7.04(a) and 7.04(b) for disability coverage claims may be extended for an additional 30-day period, provided (1) the Plan Administrator determines that such extension is due to matters beyond its control, and (2) written notification of such extension is furnished to the claimant prior to the termination of the initial 45-day period. The first 30-day extension period may be extended for a second 30-day period immediately following the first extension, provided that written notification of the extension is furnished to the claimant prior to the termination of the first 30-day extension period, indicating the date by which a decision is expected. If an extension of the disability claims determination period is necessary in order to obtain additional information from the claimant, the notice of extension under this paragraph shall include an explanation of (1) the standard on which the entitlement to a benefit is based, and (2) the additional information needed to render a decision. The claimant shall have forty-five (45) days from the date of the notice to provide such information, and the applicable claims determination period shall be tolled pending receipt of the requested information prior to the expiration of the 45-day period. Extension of review periods for group health plan benefit claims are described in Section 7.04(f)(3).

- (f) Special Requirements for Group Health Plan Claims. In addition to the foregoing requirements, this paragraph (f) shall apply to claims for benefits arising under a group health plan Benefit program.

- (1) The following definitions shall be used for the purposes of this Section 7.04(f).
 - (A) “Pre-service claim” means any claim for a benefit under a group health plan with respect to which the applicable Benefit program requires the Participant or Beneficiary to obtain approval in advance of receiving the medical care.
 - (B) “Urgent-care claim” means any claim for medical care under a group health plan with respect to which the applicable time periods for the Plan Administrator to make a non-urgent service claim determination could either (i) seriously jeopardize (1) the life health of a Participant or Beneficiary or (2) the ability of a Participant or Beneficiary to regain maximum function; or (ii) in the opinion of a physician with knowledge of the Participant’s or Beneficiary’s medical condition, would subject the Participant or Beneficiary to severe pain that cannot be adequately managed without urgent care or treatment.
 - (C) “Post-service claim” means any claim for a benefit for medical care previously rendered to a Participant or Beneficiary.
 - (D) “Concurrent care claim” means a claim for which the Plan Administrator approves ongoing treatment to be provided over a period of time.
- (2) Time Period for Submission of Claims. Claimants must submit claims for all group health plan benefits to the Plan Administrator within one year from the date service was provided. Claimants who do not submit claims for group health plan benefits within one year from the date service was provided will be ineligible to receive reimbursement from the applicable Benefit program for any expenses incurred, and the claimant will be responsible for payment of all expenses incurred.
- (3) Time Period for Review of Claims. The Plan Administrator must make an initial determination with respect to any claim for benefits under a group health plan Benefit program within the following deadlines:
 - (A) Pre-service claims. With respect to pre-service claims that are not urgent care claims, the Plan Administrator must make an initial decision within fifteen (15) days after the claim is filed. If insufficient information is provided to enable the Plan Administrator to make a determination on a pre-service claim, the Plan Administrator will notify the claimant of the Benefit program’s requirements for a pre-service claim unless the Participant, Beneficiary or authorized representative does not specify a medical condition or symptom and specific treatment, service or product for which a determination is requested.

The 15-day period for making a decision may be extended, at the discretion of the Claims Administrator, for a second 15-day period, provided that written notice is furnished to the claimant prior to the termination of the initial period, indicating the special circumstances requiring such extension of time and the date by which a final decision is expected. Pre-service claims for urgent care shall be treated as urgent care claims in accordance with Section 7.04(f)(3)(ii).

- (B) Urgent-care claims. With respect to urgent care claims (including pre-service claims for urgent care), the Claims Administrator must make an initial determination on the claim within seventy-two (72) hours after the claim is filed. If insufficient information is provided to enable the Claims Administrator to make a determination on an urgent care claim, the Claims Administrator will notify, within twenty-four (24) hours of its receipt of the urgent care claim, the claimant of the decision and information needed to enable the Claims Administrator to make a decision on such claim. The claimant must provide the requested information within a reasonable amount of time, but no less than forty-eight (48) hours after notification by the Claims Administrator of the deficiency. The Claims Administrator will then notify the claimant of its determination within forty-eight (48) hours of the earlier of its receipt of the requested information or the end of the period within which the claimant was requested to provide such additional information.
- (C) Post-service claims. With respect to post-service claims, the Plan Administrator or the Claims Administrator, as applicable, must make an initial determination on the claim within thirty (30) days after the claim is filed. The 30-day period for making a decision may be extended, at the discretion of the Plan Administrator or the Claims Administrator, as applicable, for a second 30-day period, provided that written notice is furnished to the claimant prior to the termination of the initial period, indicating the special circumstances requiring such extension of time and the date by which a final decision is expected.

- (D) Concurrent care claims. In general, concurrent care claims are treated as pre-service care claims pursuant to Section 7.04(f)(3)(i), above. However, if a group health plan Benefit program reduces or no longer covers a previously approved treatment or course of treatments prior to the end of the approved period of time for the treatment or course of treatments, the Claims Administrator must notify the claimant of the reduction or termination of coverage sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination before such Benefit is reduced or terminated. See Section 7.04(f)(4)(iv), below, regarding appeals of such adverse determinations.
- (4) Appeal of Adverse Determinations by the Claims Administrator. Appeals of adverse determinations with respect to Benefits under a group health plan Benefit program must be made to the Claims Administrator in writing (except for urgent care claims, which may be made orally as well) and must contain the reasons that the claimant believes that he or she is entitled to such Benefits as well as any additional information or documentation to support the claim for Benefits. Such appeals shall be subject to the following requirements:
- (A) Pre-service claims. Decisions on appeals of pre-service claims must be made within thirty (30) days of receipt of the appeal of the adverse determination.
 - (B) Urgent-care claims. Appeals of adverse determinations of urgent care claims may be submitted orally or in writing. Decisions on appeals of adverse decisions must be made within seventy-two (72) hours of receipt of the appeal of the adverse determination.
 - (C) Post-service claims. Decisions on appeals of post-service claims must be made within sixty (60) days of receipt of the appeal of the adverse determination.
 - (D) Concurrent care claims. If a claimant wishes to extend a treatment or course of treatments that was previously approved by the Claims Administrator, but a group health plan Benefit program subsequently reduces or terminates coverage of such treatment or course of treatments prior to the expiration of the period of time or number of treatments for which such treatment or course of treatment was approved, the claimant may appeal the reduction or termination of coverage as an adverse determination. If such appeal would be an urgent care claim, as defined above in Section 7.04(f)(1)(ii), the claimant should notify the Claims Administrator at least twenty-four (24) hours prior to the expiration of the previously approved period of time or number of treatments to request extended coverage.

If the claimant adheres to the deadlines in the previous sentence, a decision on such appeal must be made within twenty-four (24) hours of its receipt by the Claims Administrator. In all other instances, appeals regarding an adverse decision involving concurrent care claims will be treated, as applicable, as pre-service claim appeals, urgent care claim appeals, or post-service claims appeals, and subject to Sections 7.04(f)(4)(i), (ii) or (iii), as applicable.

- (g) Finality of Review on Appeal. Participants and Beneficiaries shall not be entitled to challenge the Plan Administrator's determinations in judicial or administrative proceedings without first complying with the procedures in the Plan. The decisions made pursuant to this Section 7.04 are final and binding on Participants, Beneficiaries and any other party; provided, however, that a claimant who has exhausted the administrative claims procedure set forth in the Plan may seek review of his or her claim before a court of competent jurisdiction within twelve (12) months of the date such claim is finally denied.

7.05 *Time Limit for Filing Claims*

Except to the extent that a different date certain is provided in the applicable Related Document, a claim must be filed with the Claims Administrator (or, where applicable, the Plan Administrator) by the end of the year following the calendar year in which the claim arose.

ARTICLE VIII

HIPAA PRIVACY AND SECURITY

8.01 *Disclosure of Summary Health Information*

The Plan may disclose Summary Health Information to the Employer if the Employer requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending or terminating the Plan, including analyzing Plan costs and the effectiveness of the Plan's administration or for such other purposes as may be permitted under 45 CFR §164.504(f)(1)(ii) and the provisions of this Article.

8.02 *Disclosure of Protected Health Information to Employer*

The Plan will disclose Protected Health Information to the Employer only in accordance with 45 CFR §164.504(f) and the provisions of this Article.

8.03 *Use and Disclosure of Protected Health Information*

Protected Health Information disclosed by the Plan to the Employer in accordance with the provisions of this Article may only be used by the Employer for the following purposes related to Health Care Treatment, payment for Health Care and Health Care Operations without the covered Individual's written authorization (that meets the requirements of 45 CFR §164.508) (hereinafter "permitted uses and disclosures"):

- (a) The provision, coordination, or management of Health Care and related services by one or more Health Care Providers, including the coordination or management of Health Care by a Health Care Provider with a third party, consultation between Health Care Providers relating to a patient, or the referral of a patient for Health Care from one Health Care Provider to another and such other forms of treatment as may be permitted under 45 CFR §164.502.
- (b) Activities undertaken by the Plan to obtain premiums or reimbursement, or to determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an Individual to whom Health Care is provided. These activities include, but are not limited to, the following:
 - (1) Determination of eligibility, coverage and cost sharing amounts, such as, cost of a benefit, Plan maximums and co-payments as determined for an Individual's claim;
 - (2) Coordination of benefits;
 - (3) Adjudication of health benefit claims, including appeals and other payment disputes;

- (4) Subrogation of health benefit claims;
 - (5) Establishing Employee contributions;
 - (6) Risk adjusting amounts due based on enrollee health status and demographic characteristics;
 - (7) Billing, collection activities and related Health Care data processing;
 - (8) Claims management and related Health Care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
 - (9) Obtaining payment under a contract for reinsurance, including stop-loss and excess of loss insurance;
 - (10) Medical necessity reviews or reviews of appropriateness of care or justification of charges;
 - (11) Utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;
 - (12) Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following Protected Health Information may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number, name and address of the Health Care Provider and/or health plan);
 - (13) Reimbursement to the Plan; and
 - (14) Such other payment activities as may be permitted under 45 CFR §164.502.
- (c) The activities of a Covered Entity under 45 CFR §164.502 including, but not limited to:
- (1) Conducting quality assessment and improvement activities including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities;
 - (2) Population-based activities relating to improving health or reducing Health Care costs, protocol development, case management and care coordination, disease management, contacting Health Care providers and patients with information about treatment alternatives and related functions that do not include treatment;
 - (3) Reviewing the competence or qualifications of Health Care professionals, evaluating practitioner performance, rating Health Care provider and plan performance, including accreditation, certification, licensing or credentialing activities;

- (4) Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, securing or placing a contract for reinsurance of risk relating to Health Care claims, including stop-loss insurance and excess of loss insurance;
 - (5) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
 - (6) Business planning and development, such as conducting cost-management and planning related analysis associated with managing and operating the plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
 - (7) Business management and general administrative activities of the Plan, including, but not limited to:
 - (A) Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
 - (B) Customer service, including the provision of data analysis for policyholders, plan sponsors or other customers;
 - (8) Resolution of internal grievances;
 - (9) The sale, transfer, merger or consolidation of all or part of the Covered Entity with another Covered Entity (within the meaning of 45 CFR §160.103), or an entity that following such activity will become a Covered Entity (within the meaning of 45 CFR §160.103), and due diligence related to such activity;
 - (10) Consistent with the applicable requirements of 45 CFR §164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the Covered Entity; and
 - (11) Such other Health Care Operations as may be permitted under 45 CFR §164.502.
- (d) On behalf of the Plan, the Employer may designate, with the concurrence of the appropriate Privacy Official, that the Plan, or any Health Care Component of the Plan, is part of an Organized Health Care Arrangement. If the Plan participates in an Organized Health Care Arrangement, it may disclose Protected Health Information about an Individual to another Covered Entity that participates in the Organized Health Care Arrangement for any Health Care Operation activities of the Organized Health Care Arrangement.

- (e) The Plan shall disclose Protected Health Information pursuant to an authorization that meets the requirements of 45 CFR §164.508.

8.04 *Employer Certification and Responsibility*

The Plan hereby incorporates the following provisions (a) through (j) to enable it to disclose Protected Health Information to the Employer. The Employer agrees:

- (a) To use or disclose Protected Health Information to the extent permitted in Section 8.03 of this Article, to the extent provided under HIPAA, or as otherwise Required by Law;
- (a) To ensure that any and all of their agents or subcontractors to whom the Employer provide Protected Health Information received from the Plan agree to the same restrictions and conditions as are imposed upon the Employer;
- (c) Not to use or disclose Protected Health Information for employment-related actions or in connection with any other benefit or employee benefit plan of the Employer;
- (d) To report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the permitted uses and disclosures in Section 8.03 of this Article of which it becomes aware;
- (e) To make Protected Health Information available to Individuals in accordance with 45 CFR §164.524;
- (f) To make Protected Health Information available for Individual's amendment and incorporate any amendments in accordance with 45 CFR §164.526;
- (g) To make the information available that will provide Individuals with an accounting of disclosures in accordance with 45 CFR §164.528;
- (h) To make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the U.S. Department of Health and Human Services upon request for purposes of determining compliance with HIPAA;
- (i) If feasible, to return or destroy all Protected Health Information received from the Plan that the Employer maintain in any form and retain no copies of such information when such Protected Health Information is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer, as applicable, will limit further uses and disclosures of the Protected Health Information to those purposes that make the return or destruction of the information infeasible; and
- (j) To ensure that adequate separation required by 45 CFR §164.504(f) and provided in Sections 8.05, 8.06, and 8.07 of this Article between the Plan, and the Employer, is established and maintained.

8.05 *Employees With Access To Protected Health Information*

The Plan shall disclose Protected Health Information only to the employees or other persons specified in the Plan's policies for protecting the privacy and confidentiality of Protected Health Information (the "Privacy Policy").

8.06 *Limitations To Protected Health Information Access and Disclosure*

Access to and use of Protected Health Information by the Individuals described in Section 8.05 above shall be restricted to those Plan administration functions that the Employer performs for the Plan and/or the uses set forth in Section 8.04 of this Article. Such access or use shall be permitted only to the extent necessary for these Individuals to perform their respective duties for the Plan.

8.07 *Nondisclosure of Protected Health Information by HMOs*

A Health Insurance Issuer or HMO that provides services to the Plan is not permitted to disclose Protected Health Information to the Employer except as would be permitted by the Plan under this Article and only if a Privacy Notice is maintained and provided as required by 45 CFR §164.520(a)(2)(ii).

8.08 *Notice To Employees*

The Plan shall not disclose, and may not permit a Health Insurance Issuer or HMO providing services to the Plan to disclose Protected Health Information to the Employer unless a separate statement, as set forth in 45 CFR §164.520(b)(1)(iii)(C), describing the intention of the Plan to make such disclosure, is included in a Privacy Notice that is maintained and provided as required by 45 CFR §164.520.

8.09 *Policies and Procedures*

To the extent required by HIPAA, the Employer shall adopt on behalf of the Health Plan and/or any Health Care Component of the Plan, policies and procedures as necessary to administer the terms and conditions of this Article and the Health Plan's obligations under HIPAA. Such policies and procedures shall meet the requirements of 45 CFR §164.530(i).

8.10 *Hybrid Entity Designation*

On behalf of the Plan, the Employer may designate, with the concurrence of the Privacy Official, one or more Health Care Components as part of a Hybrid Entity for purposes of complying with this Article and the HIPAA requirements. If such designation is made, the following rules shall apply:

(a) References to:

- (1) The Plan or a Covered Entity in this Article shall refer to the Health Care Component of the Plan or Covered Entity;

- (2) Health Plan, Health Care Provider or Health Care Clearinghouse in this Article shall refer to the Health Care Component of the Covered Entity if such Health Care Component performs the functions of a Health Plan, Health Care Provider or Health Care Clearinghouse, as applicable; and,
 - (3) Protected Health Information in this Article shall refer to Protected Health Information that is created or received by or on behalf of the Health Care Component of the Plan or Covered Entity.
 - (4) Electronic Protected Health Information shall refer to electronic Protected Health Information that is created, received, maintained, or transmitted by or on behalf of the Health Care Component of the Plan or Covered Entity.
- (b) The Plan shall be responsible for complying with the requirements of HIPAA, as set out in this Article, and as fully set forth in 45 CFR §164.105(a), including, but not limited to, ensuring:
- (1) That the Health Care Component does not disclose Protected Health Information and electronic Protected Health Information to another component of the Plan under circumstances where HIPAA would prohibit such disclosure if the Health Care Component and the other component were separate and distinct legal entities;
 - (2) That a Health Care Component whose activities would make it a business associate does not use or disclose Protected Health Information or electronic Protected Health Information that it creates or receives from or on behalf of the Health Care Component in a way prohibited by HIPAA; and
 - (3) That if a person performs duties for both the Health Care Component in the capacity of an Employee, volunteer, trainee or other person performing duties under the direct control of such component and for another component of the entity in the same capacity with respect to that component, such Employee, volunteer, trainee or other person performing duties under the direct control of such component must not use or disclose Protected Health Information created or received in the course of or incident to the member's work for the Health Care Component in a manner prohibited by HIPAA.
- (c) The Plan shall retain documentation of the Hybrid Entity designation for six (6) years from the date it was created or was last in effect, whichever is later, in accordance with 45 CFR §164.530(j).

8.12 *Affiliated Covered Entities*

On behalf of the Plan, the Employer may designate, with the concurrence of the Privacy Official, that the Plan, or any Health Care Component of the Plan, is part of a single Affiliated Covered Entity for purposes of complying with this Article and HIPAA. If such designation is made, the following rules shall apply:

- (a) The Affiliated Covered Entity shall ensure that Affiliated Covered Entity shall comply with the requirements of HIPAA, as set forth in this Article, and as set forth in 45 CFR §164.105.
- (b) If the Affiliated Covered Entity combines the functions of a Health Plan, Health Care Provider, or Health Care Clearinghouse, the Affiliated Covered Entity shall meet the requirements of 45 CFR §164.504(g) regarding multiple covered functions.
- (c) The Plan shall document, in writing or electronically, which Health Care Components of the Plan constitute the Affiliated Covered Entities and retain such documentation for six (6) years from the date it was created or was last in effect, whichever is later, in accordance with 45 CFR §164.530(j).

8.13 *Electronic Data Security Standards*

The Plan shall apply the following provisions to enable it to disclose electronic Protected Health Information to the Employer.

- (a) Except when electronic Protected Health Information is disclosed to the Employer with the safeguards set forth in (1) through (3) below, the Plan and Employer shall reasonably and appropriately safeguard electronic Protected Health Information that is created, received, maintained or transmitted to or by the Employer on behalf of the Plan.
 - (1) The Plan may disclose electronically Summary Health Information to the Employer if requested by the Employer for the purpose of obtaining premium bids from Health Plans, for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan in accordance with 45 CFR §504(f)(1)(ii).
 - (2) The Plan, a health insurance issuer or HMO with respect to the Plan, may disclose electronically to the Employer information on 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 in accordance with 45 CFR §504(f)(1)(iii).
 - (3) The Plan may disclose Protected Health Information to the Employer for which it has obtained from the Individual about which the Protected Health Information concerns, a valid authorization that meets the requirements of 45 CFR §164.508.
- (b) Additionally, the Employer agrees to comply with 45 CFR §164.314, including the following:

- (1) The Employer shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan.
 - (2) The Employer shall ensure that the separation requirements applicable to the Plan set out in Sections 8.05, 8.06 and 8.07 of this Article and 45 CFR §164.504(f)(2)(iii) shall be supported by reasonable and appropriate security measures.
 - (3) The Employer shall ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information, agrees to implement reasonable and appropriate security measures to protect the information.
 - (4) The Employer shall report to the Plan any security incident (within the meaning of 45 CFR §164.304) of which it becomes aware.
- (c) The Plan and the Employer shall take any such further action as is required to comply with the electronic data security standards requirements of HIPAA.

8.14 *Other Uses and Disclosures of Protected Health Information*

The Plan may disclose Protected Health Information to such other entities and under such circumstances as permitted under HIPAA and the rules, regulations, and other guidance issued by the U.S. Department of Health and Human Services under HIPAA.

ARTICLE IX

COBRA CONTINUATION COVERAGE

9.01 Continuation of Benefits Under COBRA

Qualified Beneficiaries shall have all continuation rights required by COBRA for health benefits provided under the Plan. To the extent this Plan or a Benefit Plan offering health benefits does not specify COBRA rights in accordance with Code §4980B, the Employer shall administer the continuation rights in accordance with Code §4980B. In addition, the Plan Administrator shall adopt such policies and provide such forms, as it deems advisable to implement the rights contemplated by this Section 9.01.

Notwithstanding the foregoing, this Article IX shall not apply to the Health Care Reimbursement Account. COBRA rights with respect to the Health Care Reimbursement Account are set forth in the Associated Universities, Inc. Flexible Spending Accounts Plan.

9.02 Election of COBRA

- (a) COBRA Continuation Coverage for Terminated Participants - A Qualified Beneficiary who is a Covered Employee may elect COBRA Continuation Coverage, at his own expense, if his participation under the Plan would terminate as a result of either of the following Qualifying Events:
 - (1) termination of employment (other than for gross misconduct); or
 - (2) reduction of hours of employment with the Employer.
- (b) COBRA Continuation Coverage for Qualified Dependents - A Qualified Beneficiary who is a Qualified Dependent of a Covered Employee may elect COBRA Continuation Coverage, at his own expense, if:
 - (1) his participation under the Plan would terminate as a result of a Qualifying Event; or
 - (2) the Qualified Dependent is a child born to or placed for adoption with the Covered Employee during the Covered Employee's period of COBRA Continuation Coverage; or
 - (3) the Qualified Dependent is the newly acquired spouse of a Covered Employee during the Covered Employee's period of COBRA Continuation Coverage.
- (c) A Qualified Beneficiary (or a third party on behalf of the Qualified Beneficiary) must complete and return the required enrollment materials within sixty (60) days from the later of:

- (1) loss of coverage; or
- (2) the date the Plan Administrator sends notice of eligibility for COBRA Continuation Coverage.

Failure to enroll for COBRA Continuation Coverage during this sixty (60) day period will terminate all rights to COBRA Continuation Coverage under this Article IX. A separate election as to what health coverage, if any, is desired may be made by or on behalf of each Qualified Beneficiary. However, an affirmative election of COBRA Continuation Coverage by a Covered Employee or his spouse shall be deemed to be an election for that Covered Employee's Qualified Dependents who would otherwise lose coverage under the Plan, unless the election specifically provides to the contrary. Elections for COBRA Continuation Coverage may be made by the Qualified Beneficiary or on his behalf by a third party (including a third party that is not a Qualified Beneficiary).

9.03 *Period of COBRA Coverage*

A Qualified Beneficiary who qualifies for COBRA Continuation Coverage as a result of Termination of Employment (other than for gross misconduct) or reduction in hours of employment, may elect COBRA Continuation Coverage for up to eighteen (18) months measured from the date of the Qualifying Event. With respect to all other Qualifying Events, a Qualified Beneficiary who is a Qualified Dependent may continue COBRA Continuation Coverage for up to thirty-six (36) months from the date of the Qualifying Event.

Coverage under this Section 9.03 may not continue beyond:

- (a) the date on which the Employer ceases to maintain a group health plan;
- (b) the last day of the month for which premium payments have been made, if the individual fails to make premium payments on time, in accordance with Section 9.04;
- (c) the date the Qualified Beneficiary first becomes entitled to Medicare after the date of the election of COBRA Continuation Coverage;
- (d) the date the Qualified Beneficiary first becomes covered under another group health plan after the date of the Qualifying Event and is no longer subjected, due to changes in the law or otherwise, to a pre-existing condition exclusion or limitation under the Qualified Beneficiary's other coverage or new employer plan; or
- (e) in the case of a disabled Qualified Beneficiary (and his disabled or non-disabled family members) receiving COBRA Continuation Coverage under the eleven (11) month extended coverage described in Section 9.06 herein, the month that begins more than thirty (30) days after the date the Qualified Beneficiary is determined by the Social Security Administration to no longer be "disabled" within the meaning of the Social Security Act.

9.04 *Contribution Requirements of Coverage*

Qualified Beneficiaries who elect COBRA Continuation Coverage as a result of a Qualifying Event (or third parties on behalf of a Qualified Beneficiary) will be required to pay Continuation Coverage Contributions. Qualified Beneficiaries (or third parties on behalf of a Qualified Beneficiary) must make the Continuation Coverage Contributions monthly prior to the first day of the month in which such coverage will take effect. However, a Qualified Beneficiary has forty-five (45) days from the date of an affirmative election to pay the Continuation Coverage Contributions for the period from the time coverage under the Plan would otherwise have terminated due to a Qualifying Event up through the end of the month before the month in which the first payment is made.

The Qualified Beneficiary shall have a thirty (30) day grace period from the first day of the month to which the Continuation Coverage Contributions apply. Continuation Coverage Contributions must be postmarked on or before the completion of the thirty (30) day grace period. If Continuation Coverage Contributions are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day of the month for which such premiums were made on a timely basis. The thirty (30) day grace period shall not apply to the forty-five (45) day period for payment of COBRA premiums as set out in this Section 9.04.

The Continuation Coverage Contribution of non-disabled Qualified Beneficiaries shall be up to 100% of the underwriting cost of coverage plus a 2% administrative fee for a total contribution of up to 102% of the cost of coverage.

If timely payment of the Continuation Coverage Contribution is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid is deemed to satisfy the Plan's requirement for the amount that must be paid for Continuation Coverage Contribution, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time (30 days) for payment of the deficiency to be made. For purposes of this Section an amount not significantly less than the amount the Plan requires to be paid shall be defined as not more than the lesser of fifty dollars (\$50) or ten percent (10%) of the required payment amount.

9.05 *Limitation on Qualified Beneficiary's Rights to COBRA Continuation Coverage*

If a Qualified Beneficiary loses, or will lose health coverage under the Plan as a result of divorce, legal separation or ceasing to be a Dependent, such Qualified Beneficiary or the Employee must notify the Plan Administrator within sixty (60) days of the divorce, legal separation or loss of Dependent status. Failure to make timely notification shall result in a termination of the Qualified Beneficiary's rights to COBRA Continuation Coverage under this Article IX.

A Qualified Beneficiary must notify the Plan Administrator of the birth to or placement for adoption of a child with a Covered Employee receiving COBRA Continuation Coverage. The notice must be provided within thirty (30) days of the child's birth or placement for adoption with the Qualified Beneficiary.

9.06 *Extension of COBRA Continuation Coverage Period*

If a second Qualifying Event occurs during an eighteen (18) month extension explained above, coverage may be continued for a maximum of thirty-six (36) months from the date of the first Qualifying Event for the affected Qualified Dependent. Terminating employment after a Qualifying Event that is a reduction in hours of employment does not extend the maximum coverage period beyond eighteen (18) months of COBRA Continuation Coverage.

The maximum COBRA Continuation Coverage Period is extended eleven (11) months for Qualified Beneficiaries (and their disabled or non-disabled family members receiving COBRA Continuation Coverage) for up to twenty-nine (29) months in total (measured from the date of the Qualifying Event), provided the following requirements are met:

- (a) the Social Security Administration determines that the Qualified Beneficiary is "disabled" within the meaning of the Social Security Act,
- (b) the Qualified Beneficiary was "disabled" on the date of the Qualifying Event or within the first sixty (60) days of COBRA Continuation Coverage following the Qualifying Event, and
- (c) the disabled Qualified Beneficiary provides evidence to the Plan Administrator of such Social Security Administration determination within sixty (60) days of the date of such determination but not later than the last day of the initial eighteen (18) month period of COBRA Continuation Coverage. In such event, the Continuation Coverage Contribution may be up to 150% of the cost of coverage beginning with the nineteenth month of COBRA Continuation Coverage.

9.07 *Responses to Information Regarding Qualified Beneficiary's Right to Coverage*

If a provider of health care (such as a physician, hospital, or pharmacy) contacts the Plan to confirm coverage of a Qualified Beneficiary during the election period, the Plan must give a complete response to the health care provider about the Qualified Beneficiary's COBRA Continuation Coverage rights during the election period, and his right to retroactive coverage if COBRA is elected. If a provider of health care (such as a physician, a hospital or pharmacy) contacts the Plan to confirm coverage of a Qualified Beneficiary with respect to whom the required payment has not been made for the current period, but for whom any applicable grace period has not expired, the Plan is required to inform the health care provider of all of the details of the Qualified Beneficiary's right to coverage during the applicable grace periods.

9.08 *Coordination of Benefits - Medicare and COBRA*

For purposes of this Article IX, Medicare entitlement means Medicare entitlement due to either enrollment in Medicare Parts A or B or end-stage renal disease. If a Covered Employee has a Qualifying Event due to his termination of employment or reduction in work hours, and such Qualifying Event occurs less than eighteen (18) months after the date the Covered Employee became entitled to Medicare, the maximum period of COBRA Continuation Coverage for the Covered Employee's Qualified Dependents shall be extended to the last day of the thirty-six (36) month period measured from the date of the Covered Employee's entitlement to Medicare.

9.09 *Relocation and COBRA Coverage*

If a Qualified Beneficiary moves outside the service area of a region-specific benefit package, alternative coverage (under any option that the Employer makes available to active Employees) shall be made available not later than the date of the Qualified Beneficiary's relocation, or if later, the first day of the month following the month in which the Qualified Beneficiary requests the alternative coverage.

9.10 *COBRA Coverage and HIPAA Special Enrollment Rules*

Once a Qualified Beneficiary is receiving COBRA coverage, the Qualified Beneficiary has the same right to enroll family members under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules as if the Qualified Beneficiary were an active Participant in the Plan.

9.11 *COBRA Notice Procedures*

The Plan Administrator will establish reasonable procedures for the furnishing of notices that Covered Employees or Qualified Beneficiaries are required to provide including Qualifying Event notices, second Qualifying Event notices, disability notices and change of disability status notices.

9.12 *Definitions*

For purposes of this Article IX only, the following definitions shall apply:

- (a) "Continuation Coverage" means the coverage elected by a Qualified Beneficiary as of the date of a Qualifying Event. This coverage shall be the same as the health coverage provided to Similarly Situated Beneficiaries who have not experienced a Qualifying Event as of the date the Qualified Beneficiary experiences a Qualifying Event. If the provisions of this Plan are modified for Similarly Situated Beneficiaries, such coverage shall also be modified in the same manner for all Qualified Beneficiaries as of the same date. Open enrollment rights extended to active Employees will also be extended to Similarly Situated Qualified Beneficiaries.
- (b) "Continuation Coverage Contribution" means the amount of premium contribution required to be paid by or on behalf of a Qualified Beneficiary for Continuation Coverage.

- (c) “Continuation Coverage Period” means the applicable time period for which Continuation Coverage may be elected.
- (d) “Covered Employee” means an Employee covered under this Plan on the day prior to the Qualifying Event. If an individual who otherwise would be a Covered Employee is denied coverage under the Plan in violation of applicable law, including HIPAA, the individual is considered a Covered Employee.
- (e) “Open Enrollment Period” means a period during which an Employee covered under the Plan can choose to be covered under another Plan or under another benefit option within the same plan, or add or eliminate coverage of family members.
- (f) “Qualified Beneficiary” means a Covered Employee or Qualified Dependent.
- (g) “Qualified Dependent” means:
 - (1) a Dependent covered under this Plan on the day prior to the Qualifying Event; or
 - (2) a Dependent child who is born to or placed for adoption with a Covered Employee during the Covered Employee’s period of COBRA Continuation Coverage.
- (h) “Qualifying Event” means any of the following events which would otherwise result in a Covered Employee’s or a Qualified Dependent’s loss of health coverage in the absence of this provision:
 - (1) a Covered Employee’s termination of employment, for any reason other than gross misconduct;
 - (2) a Covered Employee’s reduction in work hours resulting in a change of status such that the Covered Employee is no longer eligible to be a Covered Employee;
 - (3) a Covered Employee’s divorce or legal separation;
 - (4) a Qualified Dependent ceasing to qualify as a Dependent under the provisions of this Plan;
 - (5) a Covered Employee’s entitlement to benefits under Medicare (if the Covered Employee would lose coverage upon Medicare entitlement);
 - (6) the death of a Covered Employee; or
 - (7) the failure of a Covered Employee to return from FMLA leave.

- (8) Loss of coverage includes any increase in the premium or contribution that must be paid by the Employee (or spouse or Dependent) for coverage under the Plan that results from the occurrence of one of the events listed above in subsections (1) – (7). The loss of coverage need not occur immediately after the event, so long as the loss of coverage occurs before the end of the maximum COBRA Continuation Coverage period. If coverage is reduced or eliminated in anticipation of an event, such reduction or elimination is disregarded in determining whether the event causes a loss of coverage.
- (i) “Similarly Situated Beneficiaries” means Participants or Dependents, as applicable, who are receiving health benefits under this Plan.

ARTICLE X

GROUP HEALTH PLAN MANDATES

10.01 *Qualified Medical Child Support Order*

The Plan will comply with any Qualified Medical Child Support Order issued by a court of competent jurisdiction or through an administrative body which requires the Plan to provide medical coverage to a Dependent child of an Employee. The Plan Administrator will establish reasonable procedures for determining whether a court order requiring medical coverage to a Dependent child meets the requirements of a QMCSO. The additional cost of such coverage, if any, shall be borne by the Employee.

10.02 *Health Program Coverage of Dependent Children in Cases of Adoption*

- (a) Coverage effective upon Placement For Adoption. In any case in which a Benefit Plan provides health coverage for dependent children of Participants or Beneficiaries, such Benefit Plan shall provide benefits to dependent children placed with Participants or Beneficiaries for adoption under the same terms and conditions as apply in case of dependent children who are natural children of Participants or Beneficiaries under the Benefit Plan, irrespective of whether the adoption has become final.
- (b) Restrictions based on preexisting condition(s) at time of placement for adoption are prohibited. A Benefit Plan may not restrict coverage for any dependent Child adopted by a Participant or Placed For Adoption with a Participant, solely on the basis of a preexisting condition of such Child at the time that such Child would otherwise become eligible for coverage under the Benefit Plan, if the adoption or Placement For Adoption occurs while the Participant is eligible for coverage under such Benefit Plan.
- (c) Definitions. For purposes of this Section 10.02, the following definitions apply:
 - (1) The term “Child” means, in connection with any adoption or Placement For Adoption of the Child, an individual who has not attained age eighteen (18) as of the date of such adoption or Placement For Adoption.
 - (2) The term “Placement,” “Placement For Adoption,” or being “Placed For Adoption”, in connection with any Placement For Adoption of a Child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such Child in anticipation of adoption of such Child. The Child’s Placement with such person terminates upon the termination of such legal obligation.

10.03 Family and Medical Leave Act

If an Employee Participant takes a leave pursuant to the federal Family and Medical Leave Act of 1993, such Employee shall have the right to continue the group health Benefit Plans in which the Employee was a Participant on the same basis as active Participants from the first day on which such approved leave began until the leave ends, pursuant to the requirements of the federal Family and Medical Leave Act. An Employee Participant whose coverage terminates during a leave granted pursuant to the federal Family and Medical Leave Act because of a failure to make any contribution, if required, shall be eligible to re-enroll in the Plan immediately upon returning from the leave. Coverage shall commence on the day of his or her return to employment to active services as determined by the Plan Administrator and will be reinstated with no pre-existing condition exclusions or waiting periods (other than those applicable to eligible Employees).

10.04 Rights While on Military Leave

Pursuant to the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994, an Employee on military leave will be considered to be on a leave of absence and will be entitled during the leave to health and welfare benefits that would be made available to other similarly situated Employees if they were on a leave of absence. The Employee shall have the right to continue his coverage, including any Dependent coverage, for the lesser of the length of the leave or 24 months. If the military leave is for a period of 31 days or more, the Employee can be required to pay up to 102% of the total premium (determined in the same manner as a COBRA continuation coverage premium). If coverage is not continued during the entire period of the military leave because the employee declines to pay the premium or the leave extends beyond 24 months, the coverage must be reinstated upon reemployment with no pre-existing condition exclusions (other than for service-related illnesses or injuries) or waiting periods (other than those applicable to eligible Employees).

10.05 HIPAA Portability

The Plan shall comply with HIPAA with respect to group health coverage offered under any Benefit Plan that provides health benefits.

- (a) Eligibility - The Plan shall not base eligibility rules or waiting periods on any of the following: health status, mental or physical medical condition, genetic information, claims experience, receipt of health care, medical history, evidence of insurability (including conditions arising out of acts of domestic violence) or disability. However, the Plan may continue to provide for the exclusion of specified health conditions, or lifetime maximums on either specific benefits or all benefits provided under the Plan. These restrictions also do not preclude the Plan from applying differing benefit levels, benefit schedules of premium rates in certain situations as provided under HIPAA.

- (b) Enrollment - Special enrollment periods shall generally be provided for Employee Participants and Dependents who lose other coverage if the Employee Participant requests enrollment within thirty (30) days of the loss. Special enrollment periods shall also be available for new Dependents of a Participant as a result of marriage, birth, adoption or placement for adoption, if enrollment is requested within a period of no less than thirty (30) days following the applicable event.
- (c) HIPAA and COBRA Continuation Coverage - COBRA Continuation Coverage, as amended by HIPAA, shall be provided in accordance with the applicable Benefit Plan.
- (d) Pre-existing Conditions – With respect to health benefits, any pre-existing condition exclusions specified in a Related Document shall not exceed twelve (12) months (eighteen (18) months for late enrollees) following a Participant’s enrollment date. Pre-existing conditions limitations generally may not be applied to a newborn child or child placed for adoption with a Participant. In addition, the Plan shall not apply any pre-existing exclusions to pregnancies. Any pre-existing condition exclusion periods shall be reduced by the length of any prior “creditable coverage”, provided there was not a break in coverage that was sixty-three (63) days or longer in length (any waiting periods which must be complied with before a Participant can enroll in a Benefit Plan shall not count as a period in which there was a “break in coverage”).

10.06 *Mental Health Parity Act*

The Plan shall comply with the Mental Health Parity Act. If group health coverage offered under a Benefit Plan provides medical and surgical benefits that are subject to a lifetime aggregate limit and/or annual limit and the group health coverage offers mental health benefits, then the Benefit Plan must either 1) include payments for mental health benefits under the lifetime aggregate limit and/or annual limit, or 2) establish separate lifetime aggregate limits and/or annual limits that are greater than or equal to the health plan’s lifetime aggregate limit and/or annual limit for medical and surgical benefits. Any Benefit Plan that provides health benefits may still use cost containment methods, including cost-sharing, limits on the number of visits or days of coverage, or terms and conditions that relate to the amount, duration and scope of mental health benefits. For purposes of this Section 10.06, “mental health benefits” shall not include services for chemical dependency and or substance abuse.

10.07 *Newborns’ and Mothers’ Health Protection Act*

The Plan shall comply with the Newborns’ and Mothers’ Health Protection Act (NMHPA) with respect to group health coverage offered under any Benefit Plan that provides health benefits. Under federal law, mothers and newborn children are entitled to a hospital stay of at least 48 hours for normal delivery, and at least 96 hours for a Cesarean delivery.

10.08 Women's Health and Cancer Rights Act

The Plan will comply with the Women's Health and Cancer Rights Act with respect to any Benefit Plan that provides health benefits. A Benefit Plan that provides health coverage will provide coverage for the following medical and surgical benefits for an individual who is receiving health plan benefits in connection with a mastectomy and who has elected breast reconstruction:

- (a) Reconstruction of the breast on which the mastectomy has been performed;
- (b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- (c) Prosthesis and treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The manner of coverage will be determined in consultation with the attending physician and patient. Coverage for breast reconstruction and related services associated with a mastectomy will be subject to deductibles, copayments, coinsurance amounts, pre-certification and utilization review requirements that are consistent with those that apply to other benefits under such Benefit Plan.

10.09 Other Laws

The Plan shall comply with all other state and federal law to the extent not preempted by ERISA and to the extent such laws are applicable to Benefits provided under this Plan. Such laws shall include, but not be limited to the Americans with Disabilities Act ("ADA"), the Pregnancy Discrimination Act ("PDA"), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA").

ARTICLE XI

MISCELLANEOUS

11.01 No Employment Rights

Nothing contained in this Plan shall be construed as a contract of employment between the Employer and any Employee, nor a guarantee of any Employee to be continued in the employment of the Employer, nor as a limitation on the right of the Employer to discharge any of its Employees with or without cause.

11.02 Exclusive Benefit

The Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan. No individual shall have a right to Benefits under the Plan except as specified herein and in no event shall a right to Benefits under the Plan be or become vested.

11.03 No Assignment of Benefits

A Participant's rights, interests, or Benefits under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution of levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the Plan or Related Documents, and any such attempts shall be void. However, a Covered Person may direct, in writing, that benefits payable to him be paid instead to an institution in which he is or was hospitalized, to a provider of medical services or supplies furnished or to be furnished to him, or to a person or entity that has provided or paid for, or agreed to provide or pay for, a benefit payable under the Plan. Notwithstanding the foregoing, the Plan reserves the right to make payment directly to the Covered Person and to refuse to honor such direction and assignment. No payment by the Plan pursuant to such direction shall be considered recognition by the Plan of a duty or obligation to pay a provider of medical services or supplies except to the extent the Plan actually chooses to do so.

11.04 Clerical Error

Clerical error by the Employer or Plan Administrator shall not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

11.05 *Right to Offset Future Payments*

In the event a payment or the amount of a payment is made erroneously to an individual, the Plan shall have the right to reduce future payments payable to or on behalf of such individual by the amount of the erroneous payment. This right to offset shall not limit the right of the Plan to recover an erroneous payment in any other manner.

11.06 *Right to Recover Payments*

In the event a payment is made by the Plan with respect to Covered Expenses, in an amount in excess of the maximum amount of payment necessary at that time to satisfy the intent of the Plan, irrespective of to whom paid, the Plan shall have the right to recover such payments, to the extent of the excess, from one or more of the following, as the Plan Administrator, in its sole discretion, shall determine: a person to or for or with respect to whom the payments were made, an insurance company, or any other organization.

11.07 *Facility of Payment*

If the Plan Administrator deems any person entitled to receive any amount under the provisions of this Plan incapable of receiving or disbursing the same by reason of minority, death, illness or infirmity, mental incompetence or incapacity of any kind, the Plan Administrator may, in its discretion, direct the payment of such benefit:

- (a) Directly to such person;
- (b) To the legally appointed guardian or conservator of such person;
- (c) To a relative, friend or institution for the comfort, support and maintenance of the person entitled to receive such amount, including without limitation, any relative who had undertaken, wholly or partially, the expense of such person's comfort, care and maintenance, or any institution caring for such person; or
- (d) As directed by a court of competent jurisdiction.

The Plan Administrator may, in its discretion, deposit any amount due to a minor to his credit in any banking institution of the Plan Administrator's choice.

11.08 *Lost Payee*

Any amount due and payable to a Participant or beneficiary shall be forfeited if the Plan Administrator, after reasonable effort, is unable to locate the Participant or beneficiary to whom payment is due. Such forfeited amounts shall be applied toward Employer contributions to the Plan. However, if a claim is made by the Participant or beneficiary, any such forfeited amount will be reinstated through a special contribution to the Plan by the Employer and become payable in accordance with the terms of the Plan. The Plan Administrator shall prescribe uniform and nondiscriminatory rules for carrying out this provision.

11.09 *Misrepresentation or Fraud*

A person who receives a benefit under the Plan as a result of false information or a misleading or fraudulent representation shall repay all amounts paid by the Plan and shall be liable for all costs of collection, including attorneys' fees.

11.10 *Force Majeur*

Should the performance of any act required by the Plan be prevented or delayed by reason of a natural catastrophe, strike, lock-out, labor dispute, war, riot, or any other cause beyond the Plan's control, the time for performance of the act will be extended for a reasonable period of time, and non-performance of the act during the period of delay shall be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations under the Plan.

11.11 *No Guarantee of Tax Consequences*

Notwithstanding anything herein to the contrary, the Employer neither ensures nor makes any commitment or guarantee that any amounts paid to a Participant pursuant to the Plan or any amounts by which a Participant's wages are reduced pursuant to Article V will be excludable from the Participant's gross income or wages for federal, state or local tax purposes.

11.12 *Workers' Compensation*

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or any other laws of similar effect.

11.13 *Legal Remedy*

Before pursuing a legal remedy, an individual claiming benefits or seeking redress under the Plan shall first exhaust all claim, review, and appeal procedures available or required under the Plan.

11.14 *Governing Law*

The provisions of the Plan shall be administered, and all questions pertaining to the validity or construction of the Plan and the acts and transactions of the parties shall be determined, construed, and enforced, in accordance with applicable federal law.

11.15 *Writings Incorporated by Reference*

The documentation, as amended, listed in and attached in Appendix A is made a part of the Plan as though fully set forth herein. This document, including the Related Documents identified in Appendix A, legally governs the operation of the Plan and shall be treated as a single employee welfare benefit plan for purposes of ERISA.

11.16 *Conflicting Provisions of Related Documents*

The provisions of the Plan shall be interpreted to apply in conjunction with and in addition to the provisions of the Related Documents. In the event of a direct conflict between the provisions of a Related Document and the provisions of the Plan, relative to that particular Benefit the provisions of the Related Document shall prevail. Where terms and provisions specifically applicable to an individual Related Document are not addressed in the Plan document, such terms and provisions as set forth in such Related Document will govern.

11.17 *Severability*

If a provision of the Plan or the application of a provision of the Plan to any person, entity, or circumstance is held invalid under governing law by a court of competent jurisdiction, the remainder of the Plan and the application of the provision to any other person, entity, or circumstance shall not be affected.

11.18 *Captions and Headings*

The caption or heading of an article, section or provision of the Plan is for convenience and reference only and shall not to be considered in interpreting the terms and conditions of the Plan.

11.19 *Gender and Form*

Words used in the Plan in the masculine gender shall be construed as though they also are used in the feminine gender in all situations where they would apply. Words used in the Plan in the singular form shall be construed as though they also are used in the plural form in all situations where they would apply, and vice versa.

11.20 *Fiduciary Capacity*

Any person, or group of persons, designated by the Employer to serve in a fiduciary capacity may share a fiduciary capacity or serve in more than one fiduciary capacity with respect to the Plan.

11.21 *Waiver*

No term, condition, or provision of the Plan shall be deemed waived unless the purported waiver is in writing signed by the party to be charged. No written waiver shall be deemed a continuing waiver unless so specifically stated in the writing, and such waiver shall operate only as to the specific term, condition, or provision waived.

11.22 *Reliance by and Liability of the Parties*

The Employer, the Plan or Claims Administrator, and any person to whom a duty in connection with the administration, management, or operation of the Plan is delegated may rely upon any table, valuation, certificate, report, and/or opinion furnished by an actuary, accountant, legal counsel, or other specialist. An action taken or omitted in good faith based on such reliance shall be binding and conclusive on all parties, and no liability shall be incurred for such action or reliance, except as required by law. No liability shall be incurred for any other action or inaction of such parties except for willful misconduct or willful breach of duty to the Plan.

11.23 *Disclaimer*

None of the services provided under the Plan are warranted by the Employer and Participants shall look solely to the service provider with respect thereto. The Employer assumes no obligations other than those set forth in the Plan and shall not be liable for acts of omission or commission on the part of any Insurer, service provider, or other party.

11.24 *Bonding and Insurance*

To the extent required by ERISA or other applicable law with respect to Benefits subject to ERISA, every fiduciary of the Plan, including any Related Document, and every person handling funds of the Plan or such component thereunder shall be bonded. The Plan Administrator may apply for and obtain fiduciary liability insurance insuring the Plan against damages by reason of breach of fiduciary responsibility at the Plan's expense and insuring each fiduciary against liability to the extent permissible by law at the Employer's expense.

11.25 *Complete Statement of Plan*

The Plan supersedes all prior plans governing the types of Benefits provided under the Plan. This document, including the Related Documents, contains a complete statement of the terms of the Plan. The right of any person to any benefit of a type provided under the Plan shall be determined solely in accordance with the terms of the Plan. No other evidence, whether written or oral, shall be taken into account in determining the right of any person to any benefit of a type provided under the Plan.

11.26 *Quality of Health Services.*

The selection by the Employer of the coverages that may be financed through the Plan does not constitute any warranty, express or implied, as to the quality, sufficiency, or appropriateness of the services that may be provided by any dental, health, employee assistance plan (“EAP”), or vision care service provider, nor does the Employer assume or accept any responsibility with respect to the denial by any prospective provider of access to, or financial support for, any service, whether or not such denial is appropriate under the circumstances.

Each Employee for whom enrollment is provided under any coverage agrees, as a condition of such enrollment, that such Employee will look only to appropriately certified or licensed providers, and not to the Employer, for Benefit related services, and further that the Employee releases, discharges, indemnifies, and holds harmless the Employer, the Plan Administrator, their respective employees, officers, directors, and shareholders, and all other persons associated with them, with respect to all matters relating to (a) the quality, sufficiency, and appropriateness of dental, health, prescription drug, EAP, or vision care services provided, (b) the failure by any provider to provide any service needed, or to properly obtain informed consent prior to rendering or withholding any service, regardless of the reason for such failure, and (c) professional malpractice by a service vendor or provider, or the failure of any insurance carrier to pay for any care for which the Employee or other service recipient believes himself entitled to reimbursement.

ARTICLE XII

AMENDMENT OR TERMINATION OF PLAN

12.01 *Right to Amend*

The Employer (or its duly authorized representative) reserves the right, in its sole discretion, at will and at any time and from time to time, to modify, add, reduce, or eliminate, in whole or in part, any or all provisions of the Plan including, but not limited to, any Benefit, benefit structure, condition for or method of payment, or rate of contribution, whether applicable to all or a category of individuals.

12.02 *Right to Terminate*

The Plan established with the intention of being maintained indefinitely notwithstanding, the Employer (or its duly authorized representative) reserves the right, at will and at any time, but subject to requirements of law, to terminate the Plan.

12.03 *Effect of Amendment or Termination*

The amendment or termination of the Plan shall be effective as of the date the Employer or its duly authorized representative shall determine except that no amendment or termination shall be retroactive or reduce benefits payable for Covered Expenses prior to the later of the date the amendment or termination is effective or adopted unless otherwise required or permitted by law.

APPENDIX A

RELATED DOCUMENTS

The Plan hereby incorporates the terms and conditions of the following insurance policies, group health services agreements, certificates of insurance and booklets, attached hereto.

- A. Dental Benefits**
Delta Dental – PPO Plus Premier
• Delta Dental Evidence of Coverage – Group Number: 70083
- B. Vision Benefits**
Superior:
• Group Vision Care Plan-Administrative Service Program, Plan #28769, effective April 1, 2008.
- C. Long Term Disability Benefits**
Life Insurance Company of North America:
Certificate of Insurance for Group Life and Accidental Death and Dismemberment and Long Term Disability Insurance Program – for Group policy # LK962685
- D. Life and AD&D Benefits**
Life Insurance Company of North America:
Certificate of Insurance for Group Life and Accidental Death and Dismemberment and Long Term Disability Insurance Program – for Group policy # FLX963782 (Life) and Group policy # OK965412 (Accidental Death & Dismemberment)
- E. Business Travel Accident Benefits**
Helmsman Insurance Agency:
• Part V – Travel Accident Insurance Plan of the Insurance and Retirement Program Handbook, effective January 1, 2006
- F. Health Care Reimbursement Account**
• Associated Universities, Inc. Flexible Spending Accounts Plan