**THIS IS AN AMENDED AND RESTATED**

**DENTAL AND VISION EMPLOYEE BENEFIT PLAN**

**FOR**

# ANDREWS UNIVERSITY

**Effective Date of Amended and Restated Plan:**

**July 1, 2022**

**Group Number: G-773**

**SUMMARY OF MATERIAL MODIFICATIONS #1**

# DENTAL AND VISION EMPLOYEE BENEFIT PLAN FOR ANDREWS UNIVERSITY

The Dental and Vision Employee Benefit Plan has been amended. The changes affecting the Plan are set forth in this Summary of Material Modifications and are effective as of the dates stated herein.

Effective March 1, 2023, the Plan shall be modified as follows:

In the **DENTAL BENEFITS** section of the Plan document, the *Surgical Extraction of Impacted Teeth*, *Alveoplasty*, *Gingivectomy*, and *Vestibuloplasty* benefits in the ***TYPE II: MINOR RESTORATIVE DENTAL SERVICES*** subsection shall be revised to read as follows:

| ***Services:*** | ***Special Limitations:*** |
|---|---|
| *Surgical Extraction of Impacted Teeth* | No special limitations. |
| *Alveoplasty* | No special limitations. |
| *Gingivectomy* | No special limitations. |
| *Vestibuloplasty* | No special limitations. |

Effective July 1, 2023, the Plan shall be modified as follows:

The Vision Supply Expenses benefit in the **SCHEDULE OF VISION BENEFITS** section of the Plan document will be revised to reflect that the Maximum Benefit Paid per Covered Person per Plan Year for All Eligible Vision Supply Expenses will be increased to $350.

All other provisions of the Plan shall remain in effect and unchanged.

**ANDREWS UNIVERSITY**
**G-773**

## SPECIAL NOTE ON CLAIM FILING

**ALL BILLS MUST BE SUBMITTED TO THE PLAN WITHIN 12 MONTHS FROM THE DATE THE CHARGES WERE INCURRED IN ORDER TO BE CONSIDERED FOR PAYMENT (EXCEPT AS REQUIRED BY LAW, e.g., MEDICAID).**

**This requirement regarding the time period for filing claims shall supersede any other provision in the Plan document regarding the specific time period allowed for submitting bills or filing claims.**

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## INTRODUCTION

**ANDREWS UNIVERSITY** has established the Andrews University Employee Benefit Plan as a self-funded employer group benefits plan in order to provide certain benefits for certain Employees and their eligible Dependents. Andrews University executes this amended and restated document, including any future addenda, to re-establish this Plan for the exclusive benefit of the participating Employees and their Dependents. This document is also considered to be the Summary Plan Description and is intended to explain the Plan. Please read this document carefully and acquaint your Family with its provisions.

This Plan is not an arrangement whereby each enrollee is covered by insurance. Instead, the Employer funds claims. However, if for some reason the claims that are eligible for payment under the Plan are not paid, the individuals covered by the Plan could ultimately be responsible for those expenses.

### *NAMED FIDUCIARY AND PLAN ADMINISTRATOR*

The Named Fiduciary and Plan Administrator is **ANDREWS UNIVERSITY**. The Plan Administrator shall have the authority and discretion to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan.

### *CLAIM ADMINISTRATOR*

The Claim Administrator of the Plan is **ASR HEALTH BENEFITS** (**ASR**). The Claim Administrator shall only have the responsibilities delegated to it in writing in an Administration Agreement or other written agreement. The Claim Administrator is not a fiduciary.

The Claim Administrator processes claims and does not insure that any claims of Covered Persons will be paid.

### *PLAN ADMINISTRATOR'S OBLIGATIONS*

The Plan Administrator shall pay all benefits and expenses of the Plan from its general assets. The Plan Administrator does not establish a separate fund for the payment of Plan benefits.

## OTHER BASIC INFORMATION ABOUT THE PLAN

| | | |
|---|---|---|
| *1.* | *Plan Name*: | Andrews University Employee Benefit Plan |
| *2.* | *Group Number:* | G-773 |
| *3.* | *Employer/Plan Sponsor/ Plan Administrator:* | Andrews University<br>4150 Administration Drive<br>Berrien Springs, Michigan 49104-0840<br>(269) 471-3302 |

| | | |
|---|---|---|
| *4.* | *Employer Identification No.:* | 38-1627600 |
| *5.* | *Type of Plan:* | Welfare Benefit Plan providing dental and vision benefits |
| *6.* | *Claim Administrator:* | ASR Health Benefits<br>P.O. Box 6392<br>Grand Rapids, Michigan 49516-6392<br>(616) 957-1751 or (800) 968-2449<br>www.asrhealthbenefits.com |
| *7.* | *Type of Administration:* | The Claim Administrator administers claims for benefits pursuant to a contract with the Plan Administrator. |
| *8.* | *Agent for Service of Legal Process:* | General Counsel<br>Andrews University<br>4150 Administration Drive<br>Berrien Springs, Michigan 49104-0840<br><br>Service of process may be made upon the Plan Administrator. |
| *9.* | *Effective Date of Amended and Restated Plan:* | July 1, 2022 |
| *10.* | *Plan Year:* | July 1 through June 30 |

***PLEASE NOTE*: THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION DESCRIBES THE CIRCUMSTANCES WHEN THE PLAN PAYS FOR DENTAL AND VISION CARE. THERE MAY BE CIRCUMSTANCES WHEN YOU AND YOUR PHYSICIAN DETERMINE THAT DENTAL OR VISION CARE THAT IS NOT COVERED BY THIS PLAN IS APPROPRIATE. REMEMBER THAT ALL DECISIONS REGARDING YOUR DENTAL AND VISION CARE ARE UP TO YOU AND YOUR PHYSICIAN.**

## HOW TO FILE A VISION CLAIM

If the bill is not being submitted directly by the provider, please submit itemized copies of any bills that have been incurred to the Claim Administrator, ASR Health Benefits (ASR), via mail or e-mail as follows:

Mail: P.O. Box 6392, Grand Rapids, Michigan 49516-6392
E-mail: claimsubmit@asrhealthbenefits.com
Phone: (616) 957-1751 or (800) 968-2449

## HOW TO FILE A DENTAL CLAIM

Many dental providers will file claims on your behalf directly with the Claim Administrator. If your dental provider requires patients to file such claims themselves, obtain a claim form before going to the dentist. Contact the Employer or ASR for a claim form, or log on to ASR's Website at www.asrhealthbenefits.com to download or print a copy of the claim form. Fill in the top portion of the claim form accurately and completely. Have the dentist fill out the bottom of the claim form or send itemized copies of the bills with the claim form to the Claim Administrator via the mailing address or e-mail address stated above.

## CLAIMS HANDLING

Complete and proper claims for benefits made by Covered Persons will be promptly processed but in the event there are delays in processing claims, Covered Persons shall have no greater rights to interest or other remedies against the Claim Administrator than as otherwise afforded by law.

All information will be reviewed promptly. The Plan Administrator or ASR may request missing or additional data if needed. The Plan Administrator or ASR reserves the right to require an original claim form or billing statement.

In order for any bill to be considered, the bill must be complete. Make sure that the bill shows the patient's full name, the date that services were rendered or purchases made, the type of care or supply received, and the cost per item.

Generally, the provider of service will be automatically reimbursed unless proof of prior payment is submitted when the claim is filed. Once a claim is processed, ASR will, acting on behalf of the Plan Administrator, send the Employer or the Participant a check for the amount due and/or an "Explanation of Benefits" that is issued to others on behalf of the Covered Person. The Plan Administrator reserves the right to pay the approved portion directly to the Participant. Be sure to check for amounts that the Covered Person may be responsible for paying.

Try to keep copies of all bills and to submit expense claims to ASR as soon as each bill is received, even if the Deductible has not yet been met. Please read this booklet before a claim

occurs because certain expenses are not covered under the Plan. If you have any questions, be sure to ask the Employer or ASR.

## BENEFITS

Benefits are described and are subject to the terms and conditions set forth in the pages that follow. In-Network dental benefits are based on network-contracted rates and Out-of-Network dental benefits are based on Usual and Customary charges.

### SCHEDULE OF DENTAL BENEFITS

Coverage for dental and vision benefits comes as a combined package. Covered Persons cannot elect coverage for one benefit type without the other.

| Benefit Description | Limits (In-Network and Out-of-Network) |
|---|---|
| Plan Year (benefit-based accumulators) | July 1 through June 30 |
| Deductible per Plan Year | $25/Covered Person<br>$75/Family |
| **Special Note about Deductible:** An individual within a Family has to meet only the per-Covered Person Deductible before the Plan will begin paying benefits for Type II, Type III, and Type IV dental services. | |
| Benefit Percentage Paid | |
| Type I - Preventive Dental Services | 100%; Deductible waived<br>(0% Coinsurance) |
| Type II - Minor Restorative Dental Services | 75% after Deductible<br>(25% Coinsurance) |
| Type III - Major Restorative Dental Services | 75% after Deductible<br>(25% Coinsurance) |
| Type IV - Orthodontic Services (for Dependent children under age 24 only) | 50% after Deductible<br>(50% Coinsurance) |
| Maximum Benefits | |
| Maximum benefit paid per Covered Person per Plan Year for Types I, II, and III Dental Services | $1,100 |
| Lifetime maximum benefit paid per eligible Dependent child for Type IV Dental Services | $1,760 |
| **Special Note about Plan Year Maximum for Type I, II, and III Dental Services:** Benefits payable for Type I Preventive Dental Services rendered to Covered Persons under age 19 will not accrue toward the Plan Year maximum stated above. | |

## SCHEDULE OF VISION BENEFITS

Coverage for dental and vision benefits comes as a combined package. Covered Persons cannot elect coverage for one benefit type without the other.

| Benefit Description | Limits |
|---|---|
| Plan Year (benefit-based accumulators) | July 1 through June 30 |
| Vision Examinations | $15 co-payment per visit, then 100% (0% Coinsurance) |
| Maximum Benefit Paid per Covered Person per Plan Year for All Vision Examinations | Unlimited |
| **Special Note about Vision Examinations:** Benefits payable for vision examinations performed on Covered Persons under age 19 will be paid at 100% and no co-payment will apply. | |
| Vision Supply Expenses<br>Eyeglass Frames | 100%<br>(0% Coinsurance) |
| Eyeglass Lenses, Including Eyeglass Lens Add-Ons Such As Tinting, Ultraviolet Coatings, Scratch-Resistant Coatings, and Anti-Reflective Coatings | 100%<br>(0% Coinsurance) |
| Contact Lenses (all types) | 100%<br>(0% Coinsurance) |
| Maximum Benefit Paid per Covered Person per Plan Year for All Eligible Vision Supply Expenses | $250 |

## GENERAL BENEFIT PROVISIONS

In order for the Plan to pay any benefits, all of the following requirements must be met:

A. An expense must be incurred by a Covered Person while this Plan is effective and the Covered Person participates in the Plan. Unless otherwise provided in the Plan, a Covered Expense, loss, charge, or claim is incurred on the date that services or materials are provided.

B. The Covered Person must follow the claim procedures of this Plan.

C. The benefit must be one of the benefits described in this Plan, including all causation limitations, Deductibles, maximum limits and caps, benefit percentages, and any other payment limitations within the benefit.

D. The expense incurred by a Covered Person must be a Covered Expense payable under a benefit described in the Plan or a charge expressly covered by a benefit in the Plan.

E. The expense will be paid or reimbursed only to the extent that it is based on either a contracted schedule or on the Plan's Usual and Customary fee limitations and is submitted with appropriate procedural and diagnostic codes for the service(s) rendered.

F. The expense must not be excluded or in excess of a limitation as provided in the General Plan Exclusions and Limitations section.

G. The expense must not be payable or reimbursable by another plan whose coverage is primary to the coverage of this Plan, as provided in the Coordination of Benefits section.

If a change in the coverage of a Covered Person that increases or decreases any maximum benefit applicable to the Covered Person becomes effective in accordance with the terms of the Plan, that increase or decrease shall apply immediately.

## UTILIZATION OF IN-NETWORK DENTAL PROVIDERS

The Plan has entered into an agreement with a network of dental providers (In-Network Providers) who have agreed to provide dental care at discounted fees. For Covered Persons who use In-Network Providers, this option works in tandem with the traditional coverage under the Plan by giving those Covered Persons the opportunity to reduce their out-of-pocket expenses. Payment of charges for eligible In-Network or Out-of-Network benefits under the Plan will be made as stated in the Schedule of Benefits.

Covered Persons will be given the names of dentists, oral surgeons, and other dental providers available in their area who have agreed to be In-Network Providers. Covered Persons may also request a complete list of In-Network Providers from the Plan Administrator, which will be provided to Participants as a separate document free of charge.

Dental treatment is solely a decision between a Covered Person and their Physician. Neither the Plan Administrator nor the Claim Administrator endorses one licensed dental provider over another.

## DENTAL BENEFITS

### *BENEFIT PERCENTAGE AND DEDUCTIBLE*

Generally, the Plan will pay the percentage stated in the Schedule of Benefits, subject to the maximums stated in the Schedule of Benefits, except that the Covered Person or Family, not the Plan, must first pay the amounts necessary to satisfy the Deductibles listed in the Schedule of Benefits.

The Deductibles apply to the Covered Expenses of each Plan Year. An individual Deductible need be satisfied only once per Plan Year, regardless of the number of claims, except that once a Family has exceeded the Family Deductible, any remaining Deductibles for individuals within the Family need no longer be met. In no event shall the maximum Deductible for any one Covered Person exceed the amount stated in the Schedule of Benefits; no individual within a Family will be allowed to satisfy "extra" Deductibles in order to fulfill the Family Deductible.

### *ALLOCATION AND APPORTIONMENT OF BENEFITS*

The Plan Administrator may allocate the Deductible amount to any eligible charges and apportion the benefits to the Covered Person and any assignees. The allocation and apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

### *PLAN ADMINISTRATOR'S POWERS*

The Plan Administrator, in order to determine whether the Plan must pay benefits for the procedures submitted for consideration, may request that dental X-rays be submitted for that determination. If the X-rays are not submitted, the Plan Administrator shall have the right to determine, to the best of its ability, procedures that would provide professionally adequate restoration, replacement, or treatment. If subsequently upon receiving dental X-rays, the Plan Administrator determines that procedures other than those previously determined are more appropriate, the Plan Administrator will make adjustments to its determination of eligible expenses to the extent it deems proper.

### *TIMING OF EXPENSES*

For an appliance or modification of an appliance, an expense is considered incurred at the time the impression is made. For a crown, bridge, or gold restoration, an expense is considered incurred at the time the tooth or teeth are prepared. For root canal therapy, an expense is considered incurred at the time the pulp chamber is opened. All other expenses are considered incurred at the time a service is rendered or a supply is furnished. Expenses for appliances, dentures, fixed bridgework, crowns, or implants that were ordered before the termination date of a Covered Person, but that are installed or delivered more than 30 days after the date coverage terminates, are ineligible for payment under the Plan.

### *LIST OF DENTAL PROCEDURES*

The following is a list of dental procedures for which benefits are payable. These benefits are subject to the limitations listed below and the maximums stated in the Schedule of Benefits:

***TYPE I: PREVENTIVE DENTAL SERVICES***

| ***Services:*** | | ***Special Limitations:*** |
|---|---|---|
| *A.* | *Oral Examination* | **Covered Persons under age 19:** No special limitations.<br>**Covered Persons aged 19 and over:** Limited to two times in a Plan Year. |
| *B.* | *Dental Prophylaxis (cleaning teeth)* | Limited to two times in a Plan Year. |
| *C.* | *Complete Series or Panorex X-ray* | Limited to one time in any five-year period. |
| *D.* | *Occlusal X-rays* | No special limitations. |
| *E.* | *Extraoral X-rays* | No special limitations. |
| *F.* | *Individual Periapical X-rays* | No special limitations. |
| *G.* | *Bite-Wing X-rays* | Limited to one time in a Plan Year. |
| *H.* | *Bacteriologic Cultures* | No special limitations. |
| *I.* | *Fluoride Treatment* | **Covered Persons under age 19:** No special limitations.<br>**All other Covered Persons:** Not covered |
| *J.* | *Palliative Treatment* | Paid as a separate benefit only if no other service, except X-rays, was rendered during the visit. |
| *K.* | *Sedative Fillings* | Paid as a separate benefit only if no other service, except X-rays, was rendered during the visit. |
| *L.* | *Sealants* | Dependent children under age 14 only. |
| *M.* | *Space Maintainers* | No special limitations. |
| *N.* | *Emergency Treatment* | Exams only. |

***TYPE II: MINOR RESTORATIVE DENTAL SERVICES***

| ***Services:*** | | ***Special Limitations:*** |
|---|---|---|
| *A.* | *Periodontal Exams* | Limited to two times in any 12-consecutive-month period. |
| *B.* | *Periodontal Prophylaxis* | Limited to two times in any 12-consecutive-month period. |
| *C.* | *Diagnostic Casts* | No special limitations. |
| *D.* | *Stainless Steel Crowns* | No special limitations. |
| *E.* | *Re-cement Inlays* | No special limitations. |
| *F.* | *Re-cement Onlays* | No special limitations. |
| *G.* | *Re-cement Crowns* | No special limitations. |
| *H.* | *Re-cement Bridges* | No special limitations. |
| *I.* | *Pulpotomy* | No special limitations. |
| *J.* | *Osseous Surgery* | No special limitations. |
| *K.* | *Root Canal Therapy* | No special limitations. |
| *L.* | *Apicoectomy and Retrograde Filling* | No special limitations. |
| *M.* | *Scaling and Root Planing* | Limited to one time per quadrant of the mouth in any two-year period. |
| *N.* | *Temporary Splinting* | No special limitations. |
| *O.* | *Periodontal Appliance* | Limited to one appliance in any 36-consecutive-month period. |
| *P.* | *Repairs to Full Dentures, Partial Dentures, Bridges* | Limited to repairs or adjustments done more than 12 months after the initial insertion. |
| *Q.* | *Relining Dentures* | Limited to relining done more than 12 months after the initial insertion and then not more than one time in any 24-consecutive-month period. |

| ***Services:*** | | ***Special Limitations:*** |
|---|---|---|
| *R.* | *Simple Extraction* | No special limitations. |
| *S.* | *Surgical Extraction of Impacted Teeth* | Not covered as a dental expense if covered under the Employer's medical plan. |
| *T.* | *Alveoplasty* | Not covered as a dental expense if covered under the Employer's medical plan. |
| *U.* | *Gingivectomy* | Not covered as a dental expense if covered under the Employer's medical plan. |
| *V.* | *Vestibuloplasty* | Not covered as a dental expense if covered under the Employer's medical plan. |
| *W.* | *Root Recovery* | No special limitations. |
| *X.* | *Incision and Drainage* | No special limitations. |
| *Y.* | *Local Anesthesia* | No special limitations. |
| *Z.* | *General Anesthesia* | No special limitations. |
| *AA.* | *Amalgam Restorations (fillings)* | Multiple restorations on one surface will be treated as a single filling. |
| *BB.* | *Silicate Restorations (fillings)* | No special limitations. |
| *CC.* | *Plastic Restorations (fillings)* | No special limitations. |
| *DD.* | *Composite Restorations (fillings)* | No special limitations. |
| *EE.* | *Pin Retention* | Limited to two pins per tooth. |
| *FF.* | *Gingival Curettage* | No special limitations. |
| *GG.* | *Osseous Graft* | No special limitations. |
| *HH.* | *Frenectomy* | No special limitations. |
| *II.* | *Occlusal Adjustment* | No special limitations. |
| *JJ.* | *Bite Splint Appliances* | Limited to one appliance in any five-consecutive-year period. |

***TYPE III: MAJOR RESTORATIVE DENTAL SERVICES***

| ***Services:*** | | ***Special Limitations:*** |
|---|---|---|
| *A.* | *Gold Inlays and Onlays* | Covered only when the tooth cannot be restored by silver fillings. |
| *B.* | *Porcelain Restorations* | No special limitations. |
| *C.* | *Crowns* | Covered only if the tooth cannot be restored by a filling or by other means. |
| *D.* | *Post and Core* | No special limitations. |
| *E.* | *Replacement of Teeth to Bridges and Dentures* | No special limitations. |
| *F.* | *Full Dentures* | No special limitations. |
| *G.* | *Partial Dentures* | No special limitations. |
| *H.* | *Fixed Bridges* | No special limitations. |
| *I.* | *Dental Implants* | No special limitations. |

For replacement of items A., C., E., F., G., H., and I., see the subsection entitled "EXCLUSIONS AND LIMITATIONS FOR DENTAL BENEFITS."

***TYPE IV: ORTHODONTIC SERVICES (DEPENDENT CHILDREN UNDER AGE 24 ONLY)***

| ***Services:*** | | ***Special Limitations:*** |
|---|---|---|
| *A.* | *Orthodontic Diagnostic Procedures* | No special limitations. |
| *B.* | *Surgical Therapy* | No special limitations. |
| *C.* | *Appliance Therapy* | No special limitations. |

***EXCLUSIONS AND LIMITATIONS FOR DENTAL BENEFITS***

The following exclusions and limitations apply to dental expenses incurred by all Covered Persons. No benefits will be payable for the following:

*A.* *Initial Placement of Prosthetic Appliances, Fixed Bridges, and Implants*

Expenses incurred for initial placement of any prosthetic appliance, fixed bridge, or implant, unless placement is necessitated by the extraction of one or more

natural teeth. Any appliance, fixed bridge, or implant must include the replacement of the extracted tooth or teeth.

*B.* *Instruction on Oral Hygiene, Plaque Control, or Diet*

Expenses incurred for instruction on proper oral hygiene, plaque control, or proper diet.

*C.* *Prescription Drugs*

Expenses incurred for prescription drugs, including premedications.

*D.* *Replacement of Prosthetic Appliances, Etc.*

Expenses incurred for the replacement of any prosthetic or bite splint appliance, crown, inlay or onlay restoration, fixed bridge, or implant within five years of the date of the last placement of that appliance, crown, inlay or onlay restoration, fixed bridge, or implant unless replacement is required as a result of an accidental bodily injury sustained while the individual is a Covered Person, or because the appliance, crown, inlay or onlay restoration, fixed bridge, or implant cannot be made serviceable without replacement.

*E.* *Vertical Dimension; Occlusion*

Expenses incurred for appliances, restorations, or procedures for the purpose of altering vertical dimension or restoring or maintaining occlusion.

## VISION BENEFITS

If a Covered Person incurs covered vision expenses, the Plan will pay benefits at the percentages stated in the Schedule of Benefits, subject to the maximums stated in the Schedule of Benefits. Vision benefits are subject to any exclusions and limitations stated within this Plan or any amendments to this Plan. The following charges incurred by Covered Persons are considered Covered Expenses under this Plan:

A. Vision examinations by a Physician, including glaucoma testing.

B. Frames for prescription eyeglass lenses.

C. Eyeglass lenses that are optically required.

D. Contact lenses that are optically required.

E. Eyeglass lens add-ons such as alternative lens types, tinting, ultraviolet coatings, scratch-resistant coatings, and anti-reflective coatings.

## GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to expenses incurred by all Covered Persons and to all benefits provided by this Plan. No benefits shall be payable by the Plan for the following items:

*A.* *Charges Above Usual and Customary*

Charges that meet either of the following criteria:

1. Are in excess of Usual and Customary charges.

2. Are not in compliance with industry standards for coding and billing as set forth in prevailing industry standards and applicable law, including, but not limited to, generally accepted billing practices for unbundling or multiple procedures.

*B.* *Completion of Claim Forms*

Charges incurred for completion of insurance or benefit payment claim forms.

*C.* *Correctional Institutions*

Charges resulting from, or in connection with, a Covered Person while the Covered Person is confined in a penal or correctional institution.

*D.* *Corrective Vision Surgery*

Charges incurred for or related to radial keratotomy, radial keratectomy, Lasik, or similar procedures.

*E.* *Cosmetic Procedures*

Charges incurred in connection with the care, treatment, or surgery performed for a Cosmetic Procedure. This exclusion shall not apply to procedures necessary to lessen or correct a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease for a Covered Person.

*F.* *Effective Date of Coverage*

Charges incurred before a Covered Person's effective date of coverage under the Plan, or after coverage and any extensions of participation are terminated.

*G.* *Fees and Taxes*

Charges for sales tax, processing fees, fees for the attainment of patient records, and the like.

*H.* *Illegal Acts*

Charges incurred for an illness or injury resulting from or occurring during the commission of a violation of law by the Covered Person, including, but not limited to, the engaging in an illegal occupation or act, the commission of an assault or battery, or the operation of a Motor Vehicle while the Covered Person is under the influence of alcohol or illegal drugs, but excluding minor, non-criminal traffic violations and similar civil infractions.

*I.* *Legal Obligation to Pay Charges*

Charges incurred for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.

*J.* *Lost or Stolen*

Charges for the replacement of lost or stolen items, including eyeglasses, contact lenses, and dental appliances.

*K.* *Missed Appointments*

Charges for failure to keep an appointment.

*L.* *Motor Vehicle Exclusion (Michigan Residents Only)*

BENEFITS ARE NOT PAYABLE UNDER THIS PLAN FOR INJURIES RECEIVED IN AN ACCIDENT INVOLVING A MOTOR VEHICLE AS DEFINED IN THE PLAN. It is your responsibility to obtain proper Motor Vehicle insurance that will give you and your Family benefits. If you fail to maintain your Motor Vehicle insurance, you will not have any coverage for auto-related injuries. This exclusion shall not apply to a Covered Person who is a Michigan resident involved in an accident outside the state of Michigan for which Michigan no-fault coverage is not legally available. However, this exclusion shall apply if a Covered Person is injured while in his or her own uninsured Motor Vehicle for which a Michigan no-fault policy is legally required and would have provided coverage, had such a policy been in effect.

*M.* *Non-Accepted Treatment and Procedures*

Charges for services or supplies that meet any of the following criteria:

1. Constitute personal comfort or beautification items.

2. Are for education or training purposes.

3. Are not recognized by the dental or vision community as generally accepted care.

4. Are specifically listed by those communities as having no recognized value.

*N.* *Orthoptics; Vision Therapy*

Charges for Orthoptics or Vision Therapy.

*O.* *Over-the-Counter Products*

Charges for all over-the-counter products, even though prescribed by a Physician.

*P.* *Provider Related to Covered Person*

Charges for services rendered by a Physician to a Covered Person if the Physician is the Covered Person, a Close Relative of the Covered Person, or resides in the same household as the Covered Person.

*Q.* *War or Armed Forces Service*

Charges caused as a result of war or any act of war, whether declared or undeclared, if incurred during service (including part-time service and national guard service) in the armed forces of any country.

*R.* *Work-Related*

Charges for the treatment of an injury or illness that arose out of or in the course of any employment or occupation for wage or profit for which the Covered Person is eligible for benefits or claims or has claimed to be eligible for benefits under any workers' compensation or occupational disease law, or any similar law, whether or not he or she has applied for these benefits.

***NOTE:*** **These exclusions will not apply to the extent they would violate the Americans With Disabilities Act or any other applicable law. Further, these exclusions will not apply to the extent a court or other judicial body requires the Plan to provide coverage.**

## ELIGIBILITY AND PARTICIPATION

### SCHEDULE FOR ELIGIBILITY AND PARTICIPATION

***PARTICIPANT ELIGIBILITY REQUIREMENTS: FULL-TIME AND PART-TIME HOURLY EMPLOYEES***

In order to be eligible to participate in this Plan, an individual must be currently employed by the Employer in Full-Time or Part-Time Employment for 30 or more hours per week.

**NOTES:**

1. An individual who is eligible to participate in the Plan as both a Participant and a Dependent may enroll as a Participant or as a Dependent, but not as both.

2. Certain Employees and their eligible Dependents participating in the Plan before June 30, 2006 may be considered eligible under the Plan regardless of the above requirements. In the event that such an Employee terminates employment with the Employer, this special eligibility provision will be nullified for that individual and he or she will instead be subject to the Plan's standard Participant Eligibility Requirements for that individual's employment classification.

3. At the discretion of the Employer, the Employer may use the Look-Back/Stability Period Safe Harbor method to determine the eligibility of a Variable Hour Employee (i.e., an Employee for whom the Employer cannot determine whether the employee is reasonably expected to work an average of at least 30 hours per week during an Initial Measurement Period because the Employee's hours of service are variable or uncertain on his or her employment commencement date) to participate in the Plan. The determination to use this method will be made on a uniform, non-discriminatory basis that precludes individual selection. If the Employer elects to use the Look-Back/Stability Period Safe-Harbor method, the Employer will notify Employees who meet the criteria for coverage during an Initial or Standard Measurement Period and may enroll in the Plan during the subsequent Initial or Standard Stability Period. The Employer will also advise Employees of any special rules that apply following a transfer of employment or break in service.

***PARTICIPANT ELIGIBILITY REQUIREMENTS: ALL OTHER FULL-TIME EMPLOYEES***

In order to be eligible to participate in this Plan, an individual must be currently employed by the Employer at a 50% or more appointment percentage.

**NOTES:**

1. An individual who is eligible to participate in the Plan as both a Participant and a Dependent may enroll as a Participant or as a Dependent, but not as both.

2. At the discretion of the Employer, the Employer may use the Look-Back/Stability Period Safe Harbor method to determine the eligibility of a Variable Hour Employee (i.e., an Employee for whom the Employer cannot determine whether the employee is reasonably expected to work an average of at least 30 hours per week during an Initial Measurement Period because the Employee's hours of service are variable or uncertain on his or her employment commencement date) to participate in the Plan. The determination to use this method will be made on a uniform, non-discriminatory basis that precludes individual selection. If the Employer elects to use the Look-Back/Stability Period Safe-Harbor method, the Employer will notify Employees who meet the criteria for coverage during an Initial or Standard Measurement Period and may enroll in the Plan during the subsequent Initial or Standard Stability Period. The Employer will also advise Employees of any special rules that apply following a transfer of employment or break in service.

***PARTICIPANT EFFECTIVE DATE***

Participation in the Plan will start for new applicants on the first day on which they meet the Participant Eligibility Requirements stated above and meet the requirements described in the Participant Enrollment section below.

***EMPLOYER-PROVIDED EXTENSIONS OF PARTICIPATION***

*Medical Leave Extension of Participation*.....*Six months*

*Other Approved Leave of Absence Extension of Participation for Hourly Employees*.....*12 months*

*Other Approved Leave of Absence Extension of Participation for All Other Employees*.....*12 months or longer at the University's discretion*

*Extension of Dependent Participation Following Participant's Death*.....*Through the end of the sixth month following the month in which the death occurred*

*Severance Agreement Extension of Participation*.....*Per the terms of the agreement*

Additional information regarding Extensions of Participation is provided on page 26.

***ANNUAL OPEN ENROLLMENT PERIOD***.....*In April, May, and/or June*

Additional information regarding the Annual Open Enrollment Period is provided on page 24.

***REINSTATEMENT − TERMINATION OF EMPLOYMENT***.....*Within six months*

***REINSTATEMENT − OTHER THAN TERMINATION OF EMPLOYMENT***.....*Within six months*

***RETIREE COVERAGE***.....*Unavailable*

## INITIAL REQUIREMENTS

***PARTICIPANT ELIGIBILITY***

A person is eligible for Participant Coverage under the Plan if the person meets all of the Participant eligibility requirements listed in one of the Schedules for Eligibility and Participation.

***PARTICIPANT ENROLLMENT***

Participant Coverage begins on the first date on which the person meets both of the following requirements:

A. The person is eligible for Participant Coverage.

B. The person has made application for Participant Coverage on a form (electronic or otherwise) acceptable to the Plan Administrator.

If application for Participant Coverage is made after the first date on which coverage could begin, but within 30 days after that date, coverage will be retroactive to the first date on which coverage could have begun.

If application for Participant Coverage is not made within 30 days after the date coverage could have begun, the applicant must wait until the Annual Open Enrollment Period unless the applicant has special enrollment rights to enroll during a Special Enrollment Period. An applicant has special enrollment rights to enroll during a Special Enrollment Period in the following circumstances:

A. The applicant declined coverage when initially eligible or during a subsequent Annual Open Enrollment Period because the applicant had coverage under another group plan or health insurance coverage, and that other coverage was subsequently lost for one of the following reasons:

1. The other coverage was provided via a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, extension of participation and it has been exhausted.

2. The applicant became ineligible (i.e., as a result of a Change in Status).

3. Employer contributions for the coverage have been terminated.

4. The other coverage was an HMO, and the individual no longer lives or works in the service area of the HMO (whether or not by choice of the individual).

5. The other coverage no longer offers any benefits to a class of similarly situated individuals (e.g., part-time employees).

6. A benefit package option is terminated (unless the individual is provided a current right to enroll in alternative coverage).

7. A plan's lifetime limit on all benefits was applied.

Proof that the other coverage was lost must be provided to the Plan Administrator upon request.

An individual who lost other coverage on account of nonpayment of the required contribution or for cause (e.g., filing fraudulent claims) shall not have special enrollment rights to enroll during a Special Enrollment Period. An individual who voluntarily terminates other coverage shall not be considered to have special enrollment rights.

B. The applicant has acquired a new Dependent by marriage, birth, adoption, or placement for adoption. In this situation, special enrollment rights are available to the Employee, the Employee's spouse, any child who became a Dependent on account of the marriage, birth, adoption, or placement for adoption, and other dependents as allowed by law.

C. The applicant's coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is terminated as a result of the applicant's loss of eligibility for Medicaid or the CHIP, or the applicant becomes eligible for a premium assistance subsidy under Medicaid or a CHIP to obtain coverage under this Plan.

An applicant with special enrollment rights must make application for Participant Coverage during the Special Enrollment Period, which is generally during the first 30 days after the loss of other coverage or marriage, birth, adoption, or placement for adoption (whichever is applicable). However, if the loss of other coverage was caused by the application of the plan's lifetime limit on all benefits, the Special Enrollment Period will occur during the 30-day period immediately following the first date on which a claim was denied for that reason. Further, in the case of the loss of Medicaid or CHIP eligibility or the gain of eligibility for a Medicaid or CHIP premium assistance subsidy, the Special Enrollment Period is during the first 60 days after the loss or gain of eligibility. Participant Coverage shall be effective as of the date of the loss of other coverage, the marriage, birth, adoption or placement for adoption, the loss of Medicaid or CHIP eligibility, or the gain of eligibility for a Medicaid or CHIP premium assistance subsidy.

An applicant with special enrollment rights who fails to make application for Participant Coverage during the Special Enrollment Period must wait until the next Annual Open Enrollment Period or until special enrollment rights again apply, whichever occurs first.

All Participant Coverage under the Plan shall begin at 12:01 a.m. local time on the date on which coverage is to begin.

***DEPENDENT ELIGIBILITY***

A person is eligible for Dependent Coverage under the Plan when both of the following requirements are met:

A. The person is a Dependent.

B. The Participant on whom the person is dependent is eligible for Participant Coverage.

***DEPENDENT ENROLLMENT***

Dependent Coverage begins when all of the following requirements are met:

A. The person is eligible for Dependent Coverage.

B. The Participant on whom the person is dependent is a Covered Person.

C. The Participant makes a written application for Dependent Coverage on a form (electronic or otherwise) acceptable to the Plan Administrator on or before the first date that coverage could begin. This requirement does not apply to newly acquired Dependents by marriage, birth, or court order or decree (e.g., adoption or during the placement of the Dependent for adoption). For these Dependents, see the next paragraph below.

Notwithstanding the immediately preceding paragraph, the following special rules apply to newly acquired Dependents by marriage, birth, or court order or decree (e.g., adoption or during the placement of the Dependent for adoption):

1. A Participant's spouse may be enrolled as a Dependent as of the date of marriage if written application for Dependent Coverage for the spouse is made within 30 days of the date of marriage.

2. A Participant's newborn will be covered from the moment of birth if written application for Dependent Coverage for the child is made within 30 days of the child's date of birth. However, this requirement to make written application for a Newborn Dependent is waived if the Participant already has other Dependents covered under the Plan.

3. A Participant's spouse or child may be enrolled as a Dependent as of the date that he or she moves from a foreign country to the United States with the intent to reside in the same country as the Participant if application for Dependent Coverage for the spouse or child is made within 30 days of the date of the move. If application for Dependent Coverage is not made within 30 days of the date of the move, the applicant must wait until the Annual Open Enrollment Period unless the applicant has special enrollment rights to enroll during a Special Enrollment Period.

4. If a Dependent is acquired other than at the time of the Dependent's birth or move from a foreign country on account of marriage or a court order or decree, that Dependent may be enrolled as a Dependent as of the date of the marriage, court order or decree, if written application for Dependent Coverage for the new Dependent is made within 30 days of the court order, decree, or marriage. Dependent Coverage for a child to be placed with a Participant through adoption is effective as of the date the child is placed for adoption, if written application for Dependent Coverage for the child is made within 30 days of the child's placement. A child is considered placed for adoption if the Participant has a legal obligation for total or partial support of the child in anticipation of the child's adoption.

If application for Dependent Coverage is not made within 30 days after the date coverage could have begun, the applicant must wait until the Annual Open

Enrollment Period unless the applicant has special enrollment rights to enroll during a Special Enrollment Period. An applicant has special enrollment rights to enroll during a Special Enrollment Period in the following circumstances:

1. The applicant declined coverage when initially eligible or during a subsequent Annual Open Enrollment Period because the applicant had coverage under another group plan or health insurance coverage, and that other coverage was subsequently lost for one of the following reasons:

    a. The other coverage was COBRA, and it has been exhausted.

    b. The applicant became ineligible (i.e., as a result of a Change in Status).

    c. Employer contributions for the coverage have been terminated.

    d. The other coverage was an HMO, and the individual no longer lives or works in the service area of the HMO (whether or not by choice of the individual).

    e. The other coverage no longer offers any benefits to a class of similarly situated individuals (e.g., part-time employees).

    f. A benefit package option is terminated (unless the individual is provided a current right to enroll in alternative coverage).

    g. A plan's lifetime limit on all benefits was applied.

    Proof that the other coverage was lost must be provided to the Plan Administrator upon request.

    An individual who lost other coverage on account of nonpayment of the required contribution or for cause (e.g., filing fraudulent claims) shall not have special enrollment rights to enroll during a Special Enrollment Period. An individual who voluntarily terminates other coverage shall not be considered to have special enrollment rights.

2. The applicant has acquired a new Dependent by marriage, birth, adoption, or placement for adoption. In this situation, special enrollment rights are available to the Employee, the Employee's spouse, any child who became a Dependent on account of the marriage, birth, adoption, or placement for adoption, and other dependents as allowed by law.

3. The applicant's coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is terminated as a result of the applicant's loss of eligibility for Medicaid or the CHIP, or the applicant becomes eligible for a premium assistance subsidy under Medicaid or a CHIP to obtain coverage under this Plan.

An applicant with special enrollment rights must make application for Dependent Coverage during the Special Enrollment Period, which is generally during the first 30 days after the loss of other coverage or marriage, birth, adoption, or placement for adoption (whichever is applicable). However, if the loss of other coverage was caused by the application of the plan's lifetime limit on all benefits, the Special Enrollment Period will occur during the 30-day period immediately following the first date on which a claim was denied for that reason. Further, in the case of the loss of Medicaid or CHIP eligibility or the gain of eligibility for a Medicaid or CHIP premium assistance subsidy, the Special Enrollment Period is during the first 60 days after the loss or gain of eligibility. Dependent Coverage shall be effective as of the date of the loss of other coverage, the marriage, birth, adoption or placement for adoption, the loss of Medicaid or CHIP eligibility, or the gain of eligibility for a Medicaid or CHIP premium assistance subsidy.

An applicant with special enrollment rights who fails to make application for Dependent Coverage during the Special Enrollment Period must wait until the next Annual Open Enrollment Period or until special enrollment rights again apply, whichever occurs first.

Except for newborn coverage, which shall begin at the moment of birth, Dependent Coverage under the Plan shall begin at 12:01 a.m. local time on the date on which coverage is to begin.

***COURT- OR STATE-INITIATED QUALIFIED MEDICAL CHILD SUPPORT ORDERS***

If an Employee participating in the Plan is required to provide health care coverage for a child pursuant to a Qualified Medical Child Support Order (QMCSO) initiated by a court or state administrative agency, the following rules apply:

A. The Plan Administrator must receive notice of the order and must determine, in accordance with established procedures, that the order constitutes a QMCSO. If the Plan Administrator determines that the order constitutes a QMCSO, the remaining provisions in this section shall then apply.

B. The child may be enrolled in the Plan without regard to any enrollment season restrictions (e.g., an Annual Open Enrollment Period, if available). Further, if the Employee fails to enroll the child, the child may, in accordance with applicable law, be enrolled by the state administrative agency initiating the QMCSO or by the non-covered parent. Further, the Plan Administrator cannot refuse to enroll the child because the child was born out of wedlock, was not claimed as a dependent on the Employee's federal income tax return, or does not reside with the Employee.

C. The Employee must pay any required contributions for the child's coverage on the same basis as if the Employee elected Dependent Coverage for the child under the Plan. If the Employee fails to elect or is not eligible to elect the necessary compensation reduction contributions for the child's coverage on a before-tax basis under any Section 125 plan maintained by the Employer, the Employer may

withhold the required contributions from the Employee's paychecks on an after-tax basis to the extent permitted by applicable law.

D. If the Employee is not the custodial parent, the Plan Administrator shall provide whatever information is needed to the custodial parent for the child to obtain benefits.

E. If the Employee is not the custodial parent, the Plan Administrator shall permit the custodial parent to submit claims on behalf of the child without the approval of the Employee.

F. If the Employee is not the custodial parent, the Plan Administrator may make benefit payments to the custodial parent or the state administrative agency initiating the QMCSO, in addition to any other parties to which payment may be made as provided by the Plan.

G. The child's coverage under the Plan may not be terminated, except in the following circumstances:

1. Required contributions for coverage have not been paid in a timely manner.

2. There is written evidence that the QMCSO is no longer in effect.

3. There is written evidence that the child is or will be enrolled in comparable coverage that takes effect not later than the effective date of termination of coverage.

4. The Employer has eliminated Dependent Coverage for all participating Employees.

H. The Plan Administrator shall maintain procedures governing the determination as to whether an order constitutes a QMCSO. Covered Persons can obtain, without charge, a copy of the procedures from the Plan Administrator.

## SWITCHING COVERAGE STATUS

If a Dependent is eligible to be enrolled as a Participant, enrollment may be effective on the date of the enrollment. If a Participant is eligible to be enrolled as a Dependent, enrollment may be effective on the date of the enrollment. Any switches in coverage status do not interrupt participation in the Plan and do not change a Covered Person's effective date of coverage.

## PARTICIPANT CONTRIBUTION

The Employer may require a contribution from Participants in order to maintain Employee participation and/or the participation of any Dependents in the Plan. If Participant contributions are required, the Employer will notify the Participants of the designated amount. If the Employer maintains a Section 125 Plan, the required contributions may be paid on a pre-tax basis under that plan.

## ANNUAL OPEN ENROLLMENT PERIOD

The Plan will offer an Annual Open Enrollment Period in April, May, and/or June each year for eligible individuals and their dependents to elect coverage under this Plan. For those individuals and their dependent(s) who are eligible to enroll during the Annual Open Enrollment Period, their effective date of coverage would be July 1 following the Annual Open Enrollment Period.

An eligible individual may complete a new election form and return it to the Plan Administrator during the Annual Open Enrollment Period before the first day of the subsequent Plan Year. Further, the Plan Administrator may require an eligible individual to complete a new election form for a subsequent Plan Year. If neither one of these situations applies, an individual's election from the previous Plan Year shall automatically continue for the subsequent Plan Year.

## TERMINATION OF COVERAGE

### *PARTICIPANT TERMINATION*

Participant Coverage terminates immediately upon the earliest of the following dates, except as provided in the Extension of Participation provisions:

A. Through the end of the month in which the Participant's employment terminated.

B. Through the end of the month in which the Participant goes on a leave of absence, is laid-off, or is, on a regular basis, Actively at Work in employment by the Employer for less than the number of hours per week required to be initially eligible for coverage. However, a reduction in hours owing to a family or medical leave as defined by the FMLA shall not cause health coverage to end to the extent required by the FMLA.

C. Through the end of the month in which the Participant ceases to be in a classification (if any) shown in the Schedule for Eligibility and Participation for Participant Coverage.

D. The last day of the period for which the Participant fails to timely make any required contribution for coverage.

E. Date on which the Plan is terminated; or with respect to any benefit(s) of the Plan, the date of termination of such benefit(s).

F. Date on which the Plan Administrator terminates the Participant's coverage for cause, which includes a termination for fraud or misrepresentation (whether intentional or unintentional) in an application for enrollment or a claim for benefits. However, coverage generally cannot be retroactively rescinded absent fraud or intentional misrepresentation of a material fact.

G. Effective date of the Participant's notice of voluntary withdrawal. However, where required contributions for coverage are paid on a pre-tax basis through the

Employer's Section 125 plan, such contributions will continue to be assessed through the end of that plan's plan year unless the voluntary withdrawal occurs during the Annual Open Enrollment Period (if applicable) or midyear as a result of a Change in Status or other qualifying event under the Employer's Section 125 plan.

H. Date of the Participant's death.

Expenses incurred after the date of termination are not covered by the Plan unless an extension of participation applies (see Extensions of Participation section below).

***REINSTATEMENT − TERMINATION OF EMPLOYMENT***

If coverage for a Participant and his or her Dependents terminates because of termination of the Participant's employment and the Participant resumes eligible Full-Time Employment or Part-Time Employment with the Employer within six months, the Participant and his or her Dependents may be eligible for reinstatement of coverage under the Plan on the date on which the Participant returns to eligible Full-Time Employment or Part-Time Employment. The Participant is still considered a new Employee for any other eligibility, enrollment, or coverage requirements under the Plan. If the Participant resumes Full-Time Employment or Part-Time Employment after a longer period of time than is allowed for reinstatement, the Participant is considered a new Employee for purposes of determining when coverage begins.

***REINSTATEMENT − OTHER THAN TERMINATION OF EMPLOYMENT***

If coverage for a Participant and his or her Dependents terminates for reasons other than termination of the Participant's employment and the Participant resumes eligible Full-Time Employment or Part-Time Employment with the Employer within six months, the Participant and his or her Dependents may be eligible for reinstatement of coverage under the Plan on the date on which the Participant returns to eligible Full-Time Employment or Part-Time Employment. The Participant is <u>not</u> considered a new Employee for purposes of coverage under the Plan, and the Participant and his or her Dependents will resume the prior status attained before coverage terminated. If the Participant resumes Full-Time Employment or Part-Time Employment after a longer period of time than is allowed for reinstatement, the Participant is considered a new Employee for purposes of determining when coverage begins.

***REINSTATEMENT − ACTIVE MILITARY SERVICE***

A veteran's right and entitlement to reinstatement on returning from military training or service shall be governed by the Uniformed Services Employment and Reemployment Rights Act (USERRA), and any other applicable laws or regulations.

***DEPENDENT TERMINATION***

Dependent Coverage terminates immediately upon the earliest of the following dates, except as provided in the Extension of Participation provisions:

A. Date on which the Dependent ceases to be a Dependent.

B. Date of termination of the Participant's coverage under the Plan.

C. The last day of the period for which the Participant fails to make any required contributions for Dependent Coverage in a timely manner.

D. Date on which the Plan Administrator terminates the Dependent's coverage for cause, which includes a termination for fraud or misrepresentation (whether intentional or unintentional) in an application for enrollment or a claim for benefits. However, coverage generally cannot be retroactively rescinded absent fraud or intentional misrepresentation of a material fact.

E. Date on which the Dependent begins Participant Coverage under the Plan.

F. Date on which the Plan or a benefit of the Plan is terminated.

G. Effective date of the notice of voluntary withdrawal made by or on behalf of the Dependent. However, where required contributions for coverage are paid on a pre-tax basis through the Employer's Section 125 plan, such contributions will continue to be assessed through the end of that plan's plan year unless the voluntary withdrawal occurs during the Annual Open Enrollment Period (if applicable) or midyear as a result of a Change in Status or other qualifying event under the Employer's Section 125 plan.

H. Date of the Dependent's death.

The Participant is obligated to immediately report to the Plan Administrator any change that would result in a Dependent's termination of coverage. Expenses incurred after the date of termination are not covered by the Plan unless an extension of participation applies (see Extensions of Participation section below).

## EXTENSIONS OF PARTICIPATION

A Participant may have participation extended under Employer-provided extensions specified in the Schedule for Eligibility and Participation or under the FMLA.

Notwithstanding any of the following provisions concerning extensions of participation, coverage for the Participant or the Participant's Dependent(s) may be immediately reduced or terminated by amendment to the Plan or termination of the Plan. If an event causing the Participant's or the Dependent's coverage to terminate also causes another extension of participation, a new extension period will begin for the Participant or the Participant's Dependent(s) on the date of such event.

Coverage during an Employer-provided extension of participation shall be continued on the same basis and at the same contribution level as if the Participant had continued in active employment for the duration of the leave.

## *EMPLOYER-PROVIDED EXTENSIONS OF PARTICIPATION*

*Medical Leave Extension*

Participation for a Participant and any eligible Dependents continues if the Participant has been granted a medical leave by the Employer under policies determined on a uniform, nondiscriminatory basis that precludes individual selection. This extension of participation begins on the date on which the Participant's approved medical leave begins. However, if the Participant's medical leave of absence constitutes an FMLA leave, the extension of participation shall run concurrently with and will be offset against the length of an FMLA extension. The extension terminates upon the expiration of the six-month time period stated in the Schedule for Eligibility and Participation or the expiration of the approved medical leave, whichever occurs first.

*Approved Leave of Absence Extension*

Participation for a Participant and any eligible Dependents continues if the Participant is granted an approved leave of absence by the Employer under policies determined on a uniform, nondiscriminatory basis that precludes individual selection. This extension of participation begins on the date on which the Participant's approved leave of absence begins. However, if the Participant's approved leave of absence constitutes an FMLA leave, the extension of participation shall run concurrently with and will be offset against the length of an FMLA extension. The extension terminates upon the expiration of the applicable time period stated in the Schedule for Eligibility and Participation based on the Participant's classification or the expiration of the approved leave of absence, whichever occurs first.

*Dependents' Extension if Participant Deceased*

Participation for a Participant's Dependents continues if the Participant dies. This extension of participation begins on the date of the Participant's death and terminates at the end of the sixth month following the date of the Employee's death as stated in the Schedule for Eligibility and Participation after the Participant's death, or when the spouse remarries, whichever occurs first.

*Severance Agreement Extension*

Participation for a Participant and any eligible Dependents continues if the Participant is an Employee or is a former Employee who has entered into a severance agreement with the Employer. This extension of participation begins on the date on which the severance agreement goes into effect, and terminates on the date specified in the severance agreement. Required premiums (if any) will be specified in the severance agreement.

## *FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)*

The FMLA provisions of the Plan apply during any Calendar Year when the Employer is subject to FMLA, which generally means the Employer employs 50 or more Employees (including part-time Employees) each working day during 20 or more calendar weeks in the current or preceding Calendar Year. Further, the FMLA provisions apply only to eligible Participants (i.e., Participants who have been employed by the Employer for at least 12 months and who have worked at least 1,250 hours in the 12-month period immediately preceding the taking of the

FMLA leave). A Participant on leave under the FMLA may continue coverage during the leave on the same basis and at the same Participant contribution as if the Participant had continued in active employment continuously for the duration of the leave. The maximum period of an FMLA leave is generally 12 workweeks per 12-month period (as that 12-month period is defined by the Employer). However, if a Participant takes leave under the FMLA to care for a spouse, parent, child, or next of kin injured in the line of active military duty, the maximum period of FMLA leave is 26 workweeks per 12-month period. Other provisions regarding an FMLA leave are set forth in the FMLA and the Employer's policy regarding the FMLA. If the Participant fails to return from the FMLA leave for any reason other than the continuation, recurrence, or onset of a "serious health condition" as defined in the FMLA or other circumstance considered by the Plan Administrator as beyond the control of the Participant, the Employer may recover any Employer contribution paid to maintain coverage for the Participant during the leave. If a Participant fails to pay any required contribution for coverage during the FMLA leave within 30 days of the due date for the contribution, coverage shall be suspended upon 15 days advance written notification of the non-payment, subject to the right to reinstatement of coverage upon return to work from FMLA leave with no waiting period or other limitation normally applicable to a new Participant in the Plan.

## CONTINUATION OF COVERAGE UPON MILITARY LEAVE

If an Employee ceases to be eligible for coverage under the Plan owing to service in the U.S. military, the Plan shall comply with the requirements of the Uniformed Services Employment and Reemployment Rights Act (USERRA). These requirements include the following:

A. The Employee and any Dependents may elect to continue coverage under the Plan. Such coverage will be available until the earliest of the following:

   1. The expiration of the 24-month period following the Employee's last day of work before beginning service in the U.S. military.

   2. The end of the period allowed by law for the Employee to apply for re-employment following the Employee's service in the U.S. military.

B. If the Employee gives the Employer advance notice of the Employee's service in the U.S. military, the Plan Administrator shall provide the Employee with a notice of the right to continue coverage pursuant to USERRA. If the Employee's service in the U.S. military exceeds 30 days and the Employee fails to return the completed election form to the Plan Administrator within 60 days of the date the election form was provided to the Employee, the Employee and any Dependents shall cease to be eligible to continue coverage pursuant to USERRA as of the Employee's last day of work before beginning service in the U.S. military.

C. If the Employee fails to give the Employer advance notice of the Employee's service in the U.S. military, the coverage of the Employee and any Dependents shall be cancelled. However, the coverage of the Employee and any Dependents may be reinstated retroactively to the first day the Employee was absent from work for service in the U.S. military under all of the following circumstances:

1. The Employee is excused from providing advance notice of the Employee's service in the U.S. military as provided under USERRA regulations (e.g., it was impossible or unreasonable for the Employee to provide advance notice, or the advance notice was precluded by military necessity).

2. The Employee elects to reinstate the coverage.

3. The Employee pays all unpaid premiums for the retroactive coverage.

D. The Employee must pay for USERRA continuation coverage. Coverage continued pursuant to USERRA shall be cancelled if the Employee does not timely pay any required premiums for that coverage. The Employee's cost of the coverage is determined as follows:

1. If the period of military service is 30 days or less, the Employee's required contributions for coverage will equal the required contributions for the identical coverage paid by similarly situated active Employees.

2. If the period of military service is more than 30 days, the Employee's required contributions will be 102% of the cost of identical coverage for similarly situated active Employees.

E. The initial premium is due within 45 days after the Employee elects to continue coverage, and subsequent premiums are due on the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after the Employee initially elects USERRA continuation coverage. Coverage shall be suspended if payment is not made by the first day of the month, but will be reinstated retroactively to the first of the month as long as payment for that month is made before the end of the grace period. Payment more than 30 days late will result in automatic termination of USERRA continuation coverage pursuant to this section with no right to reinstate.

F. Upon re-employment, the coverage of the Employee and any Dependents shall be immediately reinstated under the Plan (i.e., no waiting period shall apply).

## GENERAL PROVISIONS

### COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the payment of benefits that exceed expenses. It applies when the Participant or any Dependent who is covered by this Plan is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plan(s) pay a reduced benefit. This Plan will always pay either its benefits in full or a reduced amount that, when added to the benefits payable by the other plan or plans, will not exceed 100% of Allowable Expenses. Only the amount paid by this Plan will be charged against the Plan maximums.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If another plan provides benefits in the form of service rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

The Plan Administrator and Claim Administrator may release to, and obtain from, any other insurer, plan, or party any information that it deems necessary for the purposes of this section. A Covered Person shall cooperate in obtaining information and shall furnish all information necessary to implement this provision.

***DEFINITIONS***

The term "plan," as used in this section to refer to a plan other than this Plan, means any of the following providing benefits or services for dental or vision care or treatment:

A. Group and nongroup insurance and subscriber contracts.

B. Health maintenance organization (HMO) contracts.

C. Closed panel plans or other forms of group or group-type coverage (whether insured or uninsured).

D. Benefits under group or individual automobile contracts (non-Michigan residents only).

E. Any federal governmental plan, as permitted by law.

The term "plan" as used in this section does not include any of the following:

A. Hospital indemnity coverage benefits or other fixed indemnity coverage.

B. Accident only coverage.

C. Specified disease or specified accident coverage.

D. Limited benefit health coverage, as defined by state law.

E. School accident-type coverage.

F. Benefits for non-medical components of long-term care policies.

G. Medicare supplement policies.

H. Medicaid policies.

I. Coverage under other federal governmental plans, unless permitted by law.

The term "Allowable Expense" means a health care expense, including deductibles, coinsurance and co-payments, that is covered at least in part by any plan covering the Covered Person. Any expense that is not covered by any plan covering the Covered Person is not an Allowable

Expense. Further, the amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with that plan's provisions is not an Allowable Expense.

The term "Primary Plan" means the plan that pays benefits first. The Primary Plan must pay benefits in accordance with its terms without taking into consideration the existence of another plan.

The term "Secondary Plan" means any plan that pays benefits after the Primary Plan. The Secondary Plan may reduce benefits so that the payments from all plans do not exceed 100% of the total Allowable Expense.

***MOTOR VEHICLE EXCLUSION − MICHIGAN RESIDENTS ONLY***

**BENEFITS ARE NOT PAYABLE UNDER THIS PLAN FOR INJURIES RECEIVED IN AN ACCIDENT INVOLVING A MOTOR VEHICLE AS DEFINED IN THE PLAN.** It is your responsibility to obtain proper Motor Vehicle insurance that will give you and your Family health benefits. If you fail to maintain your Motor Vehicle insurance, you will not have any health expense coverage for auto-related injuries. This exclusion shall not apply to a Covered Person who is a Michigan resident involved in an accident outside the state of Michigan for which Michigan no-fault coverage is not legally available. However, this exclusion shall apply if a Covered Person is injured while in his or her own uninsured Motor Vehicle for which a Michigan no-fault policy is legally required and would have provided coverage, had such a policy been in effect.

***COORDINATION WITH OTHER COVERAGE FOR INJURIES ARISING OUT OF AUTOMOBILE ACCIDENTS***

Notwithstanding the Payment Priorities rules set forth below, the following special coordination rule applies regarding automobile insurance. If a Covered Person is injured in an Accident involving an automobile, this Plan shall be the Primary Plan and the Covered Person's automobile insurance shall be the Secondary Plan for purposes of paying benefits.

***PAYMENT PRIORITIES***

Each plan makes its claim payment in the following order:

A. A plan that contains no provision for coordination of benefits, states that its coverage is primary, or does not have the same rules of priority as those listed below shall be the Primary Plan and pay before all other plans, including this Plan, and this Plan shall have only secondary liability.

B. A plan that covers the claimant other than as a dependent (e.g., as an employee or retiree) shall pay before the plan that covers the claimant as a dependent.

C. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan, the order of benefits is determined as follows:

   1. If the dependent child's parents are married or living together, whether or not they have ever been married, the plan of the parent whose birthday

falls first (omitting year of birth) in the Calendar Year is the Primary Plan. If both parents have the same birthday, the plan that has covered the parent the longest is the Primary Plan. This process is known as the "birthday rule."

2. If the dependent child's parents are divorced or separated or are not living together, whether or not they have ever been married, payment shall be made as follows:

   a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is the Primary Plan. This rule applies to plan years commencing after that plan is given notice of the court decree.

   b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the birthday rule will determine the order of benefits between the available plans.

   c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the birthday rule will determine the order of benefits between the available plans.

   d. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

      i. The plan covering the custodial parent.

      ii. The plan covering the spouse of the custodial parent.

      iii. The plan covering the non-custodial parent.

      iv. The plan covering the spouse of the non-custodial parent.

      For this purpose, the custodial parent is the parent awarded custody of the child by court decree. In the absence of a court decree, the parent with whom the child resides more than one-half of the Calendar Year without regard to any temporary visitation shall be considered the custodial parent.

   For purposes of this subsection, a parent's "plan" shall include any plan under which the parent has coverage (either as an employee, a dependent spouse, or otherwise).

3. If the dependent child is covered under more than one plan of individuals who are not the parents of the child, the provisions of this subsection shall determine the order of benefits as if those individuals were the parents of the child.

D. The plan that covers the claimant as an active employee or dependent of an active employee shall pay before the plan that covers the claimant as an inactive employee (e.g., an employee who is laid off or retired) or dependent of such an inactive employee. This rule does not apply if the rule under paragraph B. can determine the order of benefits.

E. If a claimant has coverage provided under COBRA or under a right of continuation by state or other federal law ("continuation coverage") and also has coverage under another plan, the plan covering the claimant as an employee or retiree (or as the dependent of an employee or retiree) is the Primary Plan and the continuation coverage is the Secondary Plan. This rule does not apply if the rule under paragraph B. can determine the order of benefits.

F. Covered Persons eligible for Medicaid shall be subject to the following provisions with respect to a state Medicaid program:

1. The Plan will pay benefits with respect to a Covered Person in accordance with any assignment of rights made by or on behalf of the Covered Person under a state plan for health care assistance approved under Title XIX of the Social Security Act (Medicaid).

2. The Plan will not take into account the fact that an individual is eligible for or receives Medicaid assistance when considering eligibility for coverage or when determining or making benefit payments under the Plan.

3. To the extent payment has been made under Medicaid in any case in which the Plan has a legal liability for such payment, then payment under this Plan will be made in accordance with any state law that provides that the state has acquired the rights with respect to a Covered Person for such payment.

G. If the order set out in paragraphs A. through F. above does not apply in a particular case, the plan that has covered the claimant for the longest period of time shall pay first. To determine the length of time a person has been covered under a plan, two or more successive plans shall be treated as one plan if the claimant was eligible under the successor plan within 24 hours after the prior plan's coverage ended.

H. If none of the preceding rules determine the order of benefits, the Allowable Expenses will be shared equally between the plans.

These coordination of benefit rules are intended to follow the National Association of Insurance Commissioners (NAIC) group coordination of benefits model regulation. The Plan's coordination of benefit rules shall be interpreted accordingly. To the extent the NAIC model

regulation is subsequently amended, the Plan's coordination of benefit rules shall be amended accordingly.

The Plan Administrator has the right to do the following:

A. Obtain from or share information with an insurance company or other organization regarding coordination of benefits, without the claimant's consent.

B. Require that the claimant provide the Plan Administrator with information regarding other plans in which the claimant may participate or be eligible to participate so that this provision may be implemented. A claimant's intentional nondisclosure under this provision shall constitute a misrepresentation in a claim for benefits for purposes of the Termination of Coverage section.

C. Pay the amount due under this Plan to an insurer or other organization if necessary, in the Plan Administrator's opinion, to satisfy the terms of this provision.

***FACILITY OF PAYMENT***

Whenever a Covered Person or provider to whom payments are directed becomes mentally, physically, or legally incapable of receiving or acknowledging receipt of such payments, neither the Employer nor the Trustee, if any, shall be under any obligation to see that a legal representative is appointed or to make payments to such legal representative if appointed. A determination of payment made in good faith shall be conclusive on all persons. The Plan Administrator, the Employer, and Trustee, if any, shall not be liable to any person as the result of a payment made and shall be fully discharged from all future liability with respect to a payment made. Payments may be made in any one or more of the following ways, as determined by the Plan Administrator in its sole discretion:

A. Directly to the Covered Person or provider.

B. To the legal representative of the Covered Person or provider.

C. To a Close Relative or other relative by blood or marriage of the Covered Person or provider.

D. To a person with whom the Covered Person or provider resides.

E. By expending the amount directly for the exclusive benefit of the Covered Person or provider.

***PLAN'S RIGHT TO REIMBURSEMENT AND SUBROGATION RIGHT***

*Plan's Right to Reimbursement*

If the Plan pays benefits and another party (other than the Covered Person or the Plan) is or may be liable for the expenses, the Plan has a right of reimbursement that entitles it to recover from

the Covered Person or another party 100% of the amount of benefits paid by the Plan to or on behalf of the Covered Person.

The Plan's right to 100% reimbursement applies to the following:

A. Not only to any recovery the Covered Person receives or is entitled to receive from the other party but also to any recovery the Covered Person receives or is entitled to receive from the other party's insurer or a plan under which the other party has coverage.

B. To any recovery from the Covered Person's own insurance policy, including, but not limited to, coverage under any uninsured or underinsured policy provisions.

C. To any recovery, even if the other party is not found to be legally at fault for causing the Covered Person to incur the expenses paid or payable by the Plan.

D. To any recovery, even if the damage recovered or recoverable from the other party, its insurer or plan, or the Covered Person's policy is not for the same charges or types of losses and damages as those for which benefits were paid by the Plan.

E. To any recovery, regardless of whether the recovery fully compensates the Covered Person for his or her injuries and illnesses and regardless whether the Covered Person is made whole by the recovery.

F. To the entire amount of the recovery to the extent of the expenses payable by the Plan. The Plan's right to reimbursement from the recovery is in the first priority and is not offset or reduced in any way by the Covered Person's attorney's fees or costs in obtaining the recovery. The Plan disavows any obligation to pay all or any portion of the Covered Person's attorney's fees or costs in obtaining the recovery. The common fund doctrine and other similar common law doctrines do not reduce or affect the Plan's right to reimbursement.

*Plan's Subrogation Right to Initiate Legal Action*

If a Covered Person does not bring an action against the other party who caused the need for the benefits paid by the Plan within a reasonable period of time after the claim arises, the Plan shall have the right to bring an action against the other party to enforce and protect its right to reimbursement. In this circumstance, the Plan shall be responsible for its own attorney's fees.

*Cooperation of Covered Person*

A Covered Person shall do whatever is necessary and shall cooperate fully to secure the rights of the Plan. This includes assigning the Covered Person's rights against any other party to the Plan and executing any other legal documents that may be required by the Plan.

*Plan's Right to Withhold Payment*

The Plan may withhold payment of benefits when it appears that a party other than the Covered Person or the Plan may be liable for the expenses until such liability is legally determined. Further, as a precondition to paying benefits when it appears that the need for the benefits payable by the Plan was caused by another party, the Plan may withhold the payment of benefits until the Covered Person signs an agreement furnished by the Plan Administrator setting forth the Plan's right to reimbursement and subrogation right.

*Preconditions to Participation and the Receipt of Benefits*

All of the following rules are preconditions to an individual's participation in the Plan and the receipt of Plan benefits:

A. The Covered Person agrees not to raise any make-whole, common fund, or other apportionment claim or defense to any action or case involving reimbursement or subrogation in connection with the Plan, and acknowledges that the Plan expressly disavows such claims or defenses.

B. The Covered Person agrees not to raise any jurisdictional or procedural issue that would defeat the Plan's claim to reimbursement or subrogation in connection with the Plan.

C. The Covered Person specifically acknowledges the Plan's fiduciary right to bring an equitable reimbursement recovery action should the Covered Person obtain or be entitled to obtain a recovery from another party who is or may be liable for the expenses paid by the Plan and to obtain an equitable lien over any property or recovery to the extent of the expenses payable by the Plan.

D. The Covered Person specifically recognizes that the Plan has the right to intervene in any third party action to enforce its reimbursement rights. The Covered Person consents to such intervention.

E. The Covered Person specifically agrees that the Plan has the right to obtain injunctive relief prohibiting the Covered Person from accepting or receiving any settlement or other recovery related to the expenses paid by the Plan until the Plan's right to reimbursement is fully satisfied. The Covered Person consents to such injunctive relief.

*Notice and Settlement of Claim*

A Covered Person shall give the Plan Administrator written notice of any claim against another party as soon as the Covered Person becomes aware that he may recover damages from another party. A Covered Person shall be deemed to be aware that he may recover damages from another party upon the earliest of the following events:

A. The date the Covered Person retains an attorney in connection with the claim.

B. The date a written notice of the claim is presented to another party or the other party's insurer or attorney by the Covered Person or by the Covered Person's insurer or attorney.

A Covered Person shall not compromise or settle any claim against another party without the prior written consent of the Plan Administrator. If a Covered Person fails to provide the Plan Administrator with written notice of a claim as required in this section, or if a Covered Person compromises or settles a claim without prior written consent as required in this section, the Plan Administrator shall deem the Covered Person to have committed fraud or misrepresentation in a claim for benefits and accordingly, shall terminate the Covered Person's participation in the Plan.

### *PROVISIONAL PAYMENT OF DISPUTED CLAIM*

In the event of a conflict between the Coordination of Benefits provisions of this Plan and any other plan, the Plan Administrator may take such action as it considers reasonably necessary to avoid hardship caused by a delay in payment of the disputed claim, including payment of such claim with reservation of the Plan's rights of recovery from the other plan in accordance with the reimbursement and subrogation provisions of this Plan.

## CLAIMS PROCEDURE

### *NOTICE AND PROOF OF CLAIM*

Written notice of injury or illness upon which a claim may be based should be given to the Plan Administrator within 30 days of the date on which the first loss occurred for which benefits arising out of such injury or illness may be claimed, or as soon as reasonably possible. The written notice must identify the claimant and the nature of the injury or illness. **Failure to provide notice within 12 months following the end of the Plan Year during which the first loss occurred for which benefits arising out of such injury or illness may be claimed shall invalidate the claim**. However, this time limit shall not apply where the reason for the delay was the failure of a third-party provider to supply evidence necessary to provide the notice or caused by some other circumstance outside the claimant's control.

The Plan Administrator, upon receiving the notice required by the Plan, will provide the claimant with any forms necessary for filing a proof of loss. If the Plan Administrator does not provide the necessary forms within 15 days after receiving such notice, the claimant can meet the requirements of the Plan regarding proof of loss by submitting (within the time frame fixed in the Plan for filing proofs of loss) written proof of the occurrence, character, and extent of the loss for which the claim is made.

A claimant may appoint an authorized representative to act on his or her behalf in pursuing a benefit claim or in appealing an adverse benefit determination. This appointment must be in writing on a form approved by the Plan.

## *EXAMINATION AND RELEASE OF INFORMATION*

The Plan Administrator shall have the right and opportunity to have a claimant examined whenever and as often as reasonably required during the pendency of a claim. The Plan Administrator shall also have the right and opportunity to have an autopsy performed in case of death, where not forbidden by law. Further, as a condition of receiving benefits under the Plan, the claimant authorizes the release of all necessary dental or vision information and records in order to process a claim.

## *INITIAL DECISION*

The Plan Administrator will notify a claimant of the Plan's benefit determination as follows:

A. Urgent Care Claims. An urgent care claim is a pre-service claim for care or treatment to which the application of the time periods for making non-urgent care claim determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or would, in the opinion of a Physician with knowledge of the claimant's condition, subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim. The Plan Administrator shall notify the claimant of the Plan's benefit determination regarding an urgent care claim as soon as possible, consistent with the medical exigencies involved, but no later than 72 hours after receipt of the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan Administrator shall notify the claimant within 24 hours after receiving the claim of the information necessary to complete the claim. The claimant shall then be granted 48 hours to provide the information. The Plan Administrator shall notify the claimant of the Plan's benefit determination within 48 hours after the earlier of the receipt of the information or the end of the period granted the claimant to provide the information.

B. Pre-Service Claims. A pre-service claim is a claim for a benefit that is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining care. The Plan Administrator shall notify the claimant of the Plan's benefit determination regarding a pre-service claim within 15 days after receipt of the claim. The Plan Administrator may extend this period one time for up to 15 days if it determines that such an extension is necessary owing to matters beyond its control. The Plan Administrator must notify the claimant, before the expiration of the initial 15-day period, of the circumstances requiring the extension and the date it expects to make a decision. If the extension is necessary because the claimant failed to submit the information required to decide the claim, the notice of the extension shall describe this required information, and the claimant will be granted 45 days from receipt of the notice to provide the information. The Plan Administrator will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the

notice of extension, the Plan Administrator may issue a denial of the claim within 15 days after the expiration of the 45-day period.

C. Post-Service Claims. A post-service claim is a claim for a benefit that is not a pre-service claim or an urgent care claim. If the Plan Administrator denies a post-service claim, in whole or in part, it shall notify the claimant of the adverse determination within 30 days after receipt of the claim. The Plan Administrator may extend this period one time for up to 15 days, if it determines that such an extension is necessary owing to matters beyond its control. The Plan Administrator must notify the claimant, before the expiration of the initial 30-day period, of the circumstances requiring the extension and the date it expects to make a decision. If the extension is necessary because the claimant failed to submit the information required to decide the claim, the notice of extension shall describe this required information, and the claimant will be granted 45 days from the receipt of the notice to provide the information. The Plan Administrator will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan Administrator may issue a denial of the claim within 15 days after the expiration of the 45-day period.

D. Concurrent Care Claims. A concurrent care claim is a claim approved by the Plan Administrator for an ongoing course of treatment to be provided over a period of time or over a number of treatments. If the Plan Administrator reduces or terminates that course of treatment (other than by Plan amendment or termination), it has issued an adverse benefit determination. The Plan Administrator will provide notice, in accordance with the Benefit Determination Notice section below, at least 30 days before reducing or terminating the course of treatment in order to give the claimant time to appeal the reduction or termination. However, special rules apply in the case of a course of treatment for urgent care. The Plan Administrator shall decide any request to extend a course of treatment for urgent care as soon as possible and shall notify the claimant of its determination within 24 hours (if the claimant makes the claim to the Plan Administrator at least 24 hours before the expiration of the prescribed course of treatment for urgent care).

***BENEFIT DETERMINATION NOTICE***

The Plan Administrator will provide the claimant with a written or electronic notification of any adverse benefit determination. An adverse benefit determination includes a denial of the claim, in whole or in part, including a partial payment of a claim. The notice will set forth the reason or reasons for the adverse determination, and refer to the Plan provisions on which the determination is based. The notice will also describe the Plan's review procedures and related time limits, and will include a statement of the claimant's right to bring a civil action following an adverse benefit determination on review. It should be noted that if the Plan is not subject to ERISA, the claimant's right to bring a civil action is not governed or protected under Section 502(a) of ERISA.

If the Plan Administrator based the adverse benefit determination upon an internal rule, guideline, protocol, or other similar criterion, the notice will state that the Plan Administrator relied upon this information and that it will provide a free copy of the same to the claimant upon request. If the Plan Administrator based the adverse benefit determination on a medically necessary, experimental treatment, or similar exclusion or limit, the notice will state that the Plan Administrator will provide an explanation of the determination free of charge to the claimant upon request.

### *APPEAL OF DENIAL*

The claimant may request a review of an adverse benefit determination by submitting a written application to the Plan Administrator within 180 days following the denial of the claim. The resubmission of a claim that has been processed by the Plan and paid or denied (in full or in part) will be considered an appeal. The claimant may submit written comments, documents, records, and other information relating to the claim. The Plan Administrator will consider the information without regard to whether it was submitted or considered in the initial benefit determination. In filing the appeal, the Plan Administrator will provide the claimant, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits. For this purpose, a document, record, or other information is relevant if the Plan Administrator relied upon it in making the benefit determination; if it was submitted, considered, or generated in the course of making the benefit determination; or if it constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The appeal procedure will provide for a review that does not defer to the initial adverse benefit determination. The appeal will be conducted by an appropriately named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor a subordinate of that individual. If the appeal is based in whole or in part on a medical judgment (including a determination of whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the appropriately named fiduciary will consult with a health care professional who has proper training and experience in the relevant field of medicine. The health care professional reviewing the appeal will not be the person who was consulted in the initial adverse benefit determination or a subordinate of that person. The Plan Administrator shall identify any experts it consulted on behalf of the Plan regarding a claimant's adverse benefit determination, whether or not it relied upon their advice.

In an appeal of an adverse benefit determination of an urgent care claim, the claimant may request an expedited appeal orally or in writing. All necessary information, including the Plan's determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or any other available, similarly expeditious method.

### *FINAL DECISION*

The Plan Administrator shall make a decision regarding a request for review as follows:

A. Urgent Care Claims. The Plan Administrator shall notify the claimant of its determination on review of an urgent care claim within 72 hours after receipt of the claimant's request for a review of an adverse benefit determination.

B. Pre-Service Claims. There shall be two levels of appeal for pre-service claims. The Plan Administrator shall notify the claimant of its determination regarding a first-level appeal within 15 days after receipt of the claimant's request for a review of an adverse benefit determination. A claimant whose first level of appeal is denied may submit a second level appeal to the Plan Administrator in writing within 60 days following the denial of the first level appeal. If the claimant submits a second appeal, the Plan Administrator shall notify the claimant of its determination regarding a second-level appeal within 15 days after receipt of the claimant's request of a second-level review of an adverse benefit determination.

C. Post-Service Claims. There shall be two levels of appeal for post-service claims. The Plan Administrator shall notify the claimant of its determination regarding a first-level appeal within 30 days after receipt of the claimant's request for a review of an adverse benefit determination. A claimant whose first level of appeal is denied may submit a second level appeal to the Plan Administrator in writing within 60 days following the denial of the first level appeal. If the claimant submits a second appeal, the Plan Administrator shall notify the claimant of its determination regarding a second-level appeal within 30 days after receipt of the claimant's request of a second-level review of an adverse benefit determination.

The Plan Administrator shall provide a claimant with written or electronic notification of its determination on review. The notice shall include the same information that was required in the notification of the initial adverse benefit determination. The decision of the Plan Administrator on appeal shall be final and binding.

The claim and appeal procedures for the Plan are governed exclusively by the provisions set forth above. Accordingly, the claim and appeal procedures of any network provider, third party administrator, insurer, or other plan shall not control.

***SPECIAL RULES***

Claimants will be provided with the following additional rights with respect to claims and appeals:

A. A claimant has the right to appeal an adverse benefit determination under the Plan, which includes a denial, reduction, termination of a benefit, or a failure to provide or make payment (in whole or in part) for a benefit. In addition, a rescission of coverage is considered an adverse benefit determination for this purpose. As a result, a claimant has the right to appeal a rescission of coverage under the Plan.

B. In connection with the appeal of an adverse benefit determination, the claimant must be provided, free of charge, with new or additional evidence considered, relied upon, or generated by the Plan in connection with a claim, as well as any new or additional rationale of the adverse benefit determination. Further, the

claimant must be provided with a reasonable opportunity to respond to the new or additional evidence or rationale.

C. The Plan cannot base decisions regarding the hiring, compensation, termination, or promotion of a claims adjudicator, medical expert, or similar individual upon the likelihood that the individual will support the Plan's denial of benefits.

D. Certain benefit determination notices and appeal notices may be required to be provided in a language other than English if ten percent or more of the population residing in the claimant's county are literate only in that other language. Further, the notices must include additional information such as information sufficient to identify the claim involved, the denial code and its corresponding meaning, any standard used in denying the claim, and a description of the available internal appeals and external review processes.

E. The Legal Proceedings subsection states that no court action may be brought by a claimant until exhausting the Claims Procedure provisions of the Plan. If the Plan fails to strictly adhere to the internal claim and appeal procedures, the claimant is deemed to have exhausted the internal claim and appeal procedures. As a result, the claimant may initiate an external review and/or file a legal proceeding. However, this rule shall not apply to minor, de minimis violations.

F. A Plan must offer an external review process. The Plan may be subject to the applicable state external review process for fully-insured health plans and non-ERISA self-funded health plans. Otherwise, the Plan will offer an external review procedure which satisfies U.S. Department of Labor regulations. Information about the external review process is as follows:

1. The primary type of external review is a standard external review. A claimant must file a request for a standard external review within four months after the date of receipt of a notice of adverse benefit determination or final internal adverse benefit determination.

2. Within five business days following the date of receipt of the external review request, the Plan must complete a preliminary review of the request to determine whether all of the following has occurred:

   a. The claimant had coverage under the Plan at the time the service or supply was provided.

   b. The claimant has exhausted the Plan's internal appeal process unless not required to do so as described above.

   c. The claimant has provided all information and forms necessary to process the external review.

3. Within one business day after completing the preliminary review, the Plan will issue a written notification to the claimant. If the request is complete but not eligible for external review, the notification will include the

reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. In such case, the Plan will allow the claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

4. If the Plan determines that an adverse benefit determination or final internal adverse benefit determination is eligible for external review, the Plan shall assign the external review to an independent review organization ("IRO") that is accredited by URAC or by a similar nationally recognized accrediting organization. The Plan shall take action against bias and to ensure independence. The Plan shall have contracts in place with at least three IROs, and external reviews shall be rotated among the IROs. In addition, an IRO shall not be eligible for any financial incentive based on the likelihood that the IRO will support the denial of benefits. The IRO shall follow the procedure below:

   a. The assigned IRO will notify the claimant in writing of the request's eligibility and acceptance for external review. In order to be eligible for external review, the adverse benefit determination or final internal adverse benefit determination must involve a medical judgment or rescission of coverage. The IRO shall make this determination when considering the request's eligibility for external review. If accepted, the notice will include a statement that the claimant may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information for the IRO to consider when conducting the external review.

   b. Within five business days after the date of the assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

   c. Upon any receipt of any information submitted by the claimant, the IRO must, within one business day, forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination. The external review may be terminated as a result of the reconsideration only if the Plan

reverses its adverse benefit determination or final internal adverse benefit determination and provides coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO shall terminate the external review upon receipt of the notice from the Plan.

d. The IRO will review all the information and documents timely received. In reaching a decision the assigned IRO will review the claim "de novo" (i.e., anew) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO may also consider additional documents and information in conducting the external review, including the claimant's dental or vision records; the attending health care professional's recommendation; reports from appropriate health care professionals; other documents submitted by the Plan, claimant, or claimant's treating provider; the terms of the Plan; appropriate practice guidelines (including applicable evidence-based standards); any applicable clinical review criteria developed and used by the Plan, unless inconsistent with the terms of the Plan or applicable law; and the opinion of the IROs clinical reviewer(s).

e. The IRO must provide written notice of its final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of its final external review decision to the claimant and the Plan.

f. The IRO's decision notice will contain a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date[s] of service, the health care provider, the claim amount [if applicable], the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial), the date that the IRO received the assignment to conduct the external review, the date of the IRO decision, references to the evidence or documentation considered in reaching its decision, a discussion of the principal reason(s) for its decision, a statement that the determination is binding except to the extent that other remedies may be available under state or federal law, a statement that judicial review may be available, and current contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act.

g. After a final external review, the IRO must maintain records of all claims and notices associated with the external review for six years. The IRO must make such records available for examination

by the claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

5. Upon receipt of a notice of final external review reversing the adverse benefit determination or final internal adverse benefit determination, the Plan must immediately provide coverage or payment in connection with the claim.

6. The second type of external review is an expedited external review. The Plan must allow a claimant to make a request for an expedited external review in two situations. First, an expedited external review is available where the claimant has received an adverse benefit determination and it involves a dental or vision condition of the claimant for which the time frame for completing an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited external appeal. Second, an expedited external review is available where the claimant has received a final internal adverse benefit determination and the claimant has a dental or vision condition where the time frame for completing a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged for a facility. The Plan and the IRO shall follow the procedure below for an expedited external review:

   a. Immediately upon the receipt of a request for an expedited external review, the Plan must determine whether the request meets the review ability requirements set forth above for a standard external review. The Plan must immediately send a written notice that meets the requirements set forth above for a standard external review to the claimant regarding its eligibility determination.

   b. Upon a determination that the request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for a standard external review. The Plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse determination to the assigned IRO electronically, by telephone, by facsimile, or by any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents under the same procedures for a standard external review. In reaching a decision, the IRO must review the claim "de novo" (i.e.,

anew) and is not bound by any decisions or conclusions reached during the Plan's internal claim and appeals process.

c. The IRO shall provide notice of its decision in the same manner as a standard external review and shall do so as expeditiously as the claimant's dental or vision condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.

***LEGAL PROCEEDINGS***

No action at law or in equity shall be brought by a claimant to recover a claim on the Plan before the exhaustion of remedies provided under the Claims Procedure provisions of the Plan, nor shall such action be brought at all, unless brought by the last day of the Plan Year after the Plan Year in which the claimant was provided with a written notice denying the final level of Plan appeal concerning the claim.

***NO INTEREST***

The Plan shall not be required to pay interest on any claim for Plan benefits regardless of when paid.

***UNCLAIMED PROPERTY / ESCHEAT***

If a check for the payment of Plan benefits is not negotiated within one year after the date it is issued, the check shall be dishonored.

***CLAIM PROCEDURES FOR DISABILITY-BASED CLAIM DETERMINATIONS***

If a claim for Plan benefits with respect to an adult Dependent child is denied because it is determined that the child does not satisfy all the requirements to be considered disabled for purposes of the Plan (a "disability claim"), the claimant will have additional appeal rights in accordance with U.S. Department of Labor regulations. This subsection shall apply in this instance.

*Notice and Proof of Claim*

The Plan Administrator will provide the claimant with any forms necessary for filing a claim. Written notice of injury or illness upon which a claim may be based should be given to the Plan Administrator within 30 days of the date on which the first loss occurred for which benefits arising out of such injury or illness may be claimed, or as soon as reasonably possible. **Failure to provide notice within 12 months following the end of the Plan Year during which the first loss occurred for which benefits arising out of such injury or illness may be claimed shall invalidate the claim**. However, this time limit shall not apply where the reason for the delay was the failure of a third-party provider to supply evidence necessary to provide the notice or caused by some other circumstance outside the claimant's control.

A claimant may appoint an authorized representative to act on his or her behalf in pursuing a benefit claim or in appealing an adverse benefit determination. This appointment must be in writing on a form approved by the Plan.

*Examination and Release of Information*

The Plan Administrator shall have the right and opportunity to have a claimant examined whenever and as often as reasonably required during the pendency of a claim. The Plan Administrator shall also have the right and opportunity to have an autopsy performed in case of death, where not forbidden by law. Further, as a condition of receiving benefits under the Plan, the claimant authorizes the release of all necessary dental or vision information and records in order to process a claim.

*Initial Decision*

The Plan Administrator will notify a claimant of the Plan's benefit determination. If a disability claim is denied, in whole or in part, the Plan Administrator must notify the claimant of the adverse benefit determination within a reasonable period of time, but no longer than 45 days after receipt of the claim. The Plan Administrator may extend this period for up to 30 days, if it determines that such an extension is necessary owing to matters beyond its control, including situations in which the claim for benefits is incomplete.

The Plan Administrator must notify the claimant, before the expiration of the initial 45-day period, of the circumstances requiring the extension and the date it expects to make a decision. The Plan Administrator may prolong this first 30-day extension period for up to 30 additional days, if it determines that the additional time is necessary owing to matters beyond its control. The Plan Administrator must notify the claimant, before the expiration of the first 30-day extension period, of the circumstances requiring the second extension and the date it expects to make a decision.

Any extension notice must include an explanation of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim (i.e., the reason for the extension), and the additional information needed to resolve those issues (if applicable).

The claimant will be granted 45 days to provide the required information. The Plan Administrator will have 30 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan Administrator may issue a denial of the claim within 30 days after the expiration of the 45-day period.

An adverse benefit determination includes a denial of the claim, in whole or in part, including a partial payment of a claim. The Plan Administrator must provide the claimant with a written or electronic notification of any adverse benefit determination that satisfies the requirements below (see the Adverse Benefit Determination Notice subsection). In addition, the notice must include the following:

A. A description of any additional material or information necessary for the claimant to perfect the claim for benefits and an explanation of why such material or information is necessary.

B. A description of the Plan's review procedures and related time limits applicable to such procedures, including, if the Plan is subject to ERISA, a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA.

*Appeal of Adverse Benefit Determination*

In filing an appeal (either the first-level or the voluntary second-level appeal), the Plan Administrator will provide the claimant, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits. For this purpose, a document, record, or other information is relevant to the claim for benefits as follows:

A. It was relied upon in making the adverse benefit determination.

B. It was submitted, considered, or generated in the course of making the adverse benefit determination, regardless of whether it was relied upon in making the adverse benefit determination.

C. It demonstrates compliance with the administrative processes and safeguards used to verify that benefit claim determinations are made in accordance with the Plan's terms, and where appropriate, the Plan's terms have been applied consistently with respect to similarly situated claimants.

D. It constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, regardless of whether such policy or guidance was relied upon in making the adverse benefit determination.

The appeal procedure will provide for a review that does not defer to the previous adverse benefit determination. The appeal will be conducted by an appropriately named fiduciary of the Plan who is neither the individual who made the previous adverse benefit determination nor a subordinate of that individual. If the appeal is based in whole or in part on a medical judgment (including a determination of whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the appropriately named fiduciary will consult with a health care professional who has proper training and experience in the relevant field of medicine. The health care professional reviewing the appeal will not be the person who was consulted in the previous adverse benefit determination or a subordinate of that person. The Plan Administrator shall identify any experts it consulted on behalf of the Plan regarding a claimant's adverse benefit determination, whether or not it relied upon their advice.

*First Level of Appeal*

The claimant may request a review of the initial adverse benefit determination by submitting a written application to the Plan Administrator within 180 days following the initial adverse benefit determination. The claimant may submit written comments, documents, records, and other information relating to the claim. The Plan Administrator will consider the information without regard to whether it was submitted or considered in the initial benefit determination.

The Plan Administrator will notify the claimant of its determination on review regarding a disability claim within 45 days after receipt of the claimant's request for a review of the initial adverse benefit determination. The Plan Administrator may extend this period one time for up to 45 days if it determines that special circumstances require an extension of the time for processing the claim. The Plan Administrator must notify the claimant, before the expiration of the initial 45-day period, of the special circumstances requiring an extension and the date that it expects to make its decision.

The Plan Administrator must provide the claimant with a written or electronic notification of any adverse benefit determination on review that satisfies the requirements below (see the Adverse Benefit Determination Notice subsection). In addition, if the Plan is subject to ERISA, the notice must include a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA.

*Voluntary Second Level of Appeal*

The claimant may request a review of the adverse benefit determination on review (i.e., a second-level appeal) by submitting a written application to the Plan Administrator within 60 days following the adverse benefit determination on review (i.e., the first-level appeal). The claimant may submit written comments, documents, records, and other information relating to the claim. The Plan Administrator will consider the information without regard to whether it was submitted or considered in a previous adverse benefit determination.

The Plan Administrator will notify the claimant of its determination on review regarding the disability claim within 45 days after receipt of the claimant's request for a review of the previous adverse benefit determination. The Plan Administrator may extend this period one time for up to 45 days if it determines that special circumstances require an extension of the time for processing the claim. The Plan Administrator must notify the claimant, before the expiration of the initial 45-day period, of the special circumstances requiring an extension and the date that it expects to make its decision.

The Plan Administrator must provide the claimant with a written or electronic notification of any adverse benefit determination on review that satisfies the requirements below (see the Adverse Benefit Determination Notice subsection). In addition, if the Plan is subject to ERISA, the notice must include a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA.

*Adverse Benefit Determination Notice*

Any adverse benefit determination notice must be provided in a culturally and linguistically appropriate manner and include the following:

A. The specific reason or reasons for the adverse benefit determination.

B. A reference to the specific Plan provisions on which the adverse benefit determination is based.

C. A discussion of the Plan Administrator's decision, including an explanation of the basis for disagreeing with the following:

1. The views presented by the claimant of health care professionals treating the claimant and vocational professionals who evaluated the claimant.

2. The views of experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, regardless of whether the Plan Administrator relied upon this advice in making the adverse benefit determination.

3. A disability determination presented by the claimant made by the Social Security Administration.

D. An explanation of the scientific or clinical judgment for the adverse benefit determination or a statement that such explanation will be provided free of charge upon request, applying the terms of the Plan to the claimant's circumstances, if the adverse benefit determination is based on a medical necessity, experimental treatment, or similar exclusion or limit.

E. The specific internal rules, guidelines, protocols, standards, or similar criteria of the Plan that were relied upon by the Plan in making an adverse benefit determination, or a statement that such internal rules, guidelines, protocols, standards, or similar criteria of the Plan do not exist.

F. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits. For this purpose, the determination of whether a document, record, or other information is relevant to the claim for benefits is based on the same four factors listed above (see the Appeal of Adverse Benefit Determination subsection).

*Special Rules*

Claimants will be provided with the following additional rights with respect to claims and appeals:

A. A claimant has the right to appeal an adverse benefit determination under the Plan, which includes a denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) for a benefit. In addition, a rescission of coverage is considered an adverse benefit determination for this purpose. As a result, a claimant has the right to appeal a rescission of coverage under the Plan.

B. In connection with the appeal of an adverse benefit determination (either the first-level or the voluntary second-level appeal), the claimant must be provided, free of charge, with the following:

1. New or additional evidence considered, relied upon, or generated by the Plan in connection with the claim.

2. New or additional rationale on which the adverse benefit determination is based.

The claimant must be provided with this new or additional information as soon as possible and sufficiently in advance of the date the Plan issues an adverse benefit determination on review so that the claimant has a reasonable opportunity to respond to the new or additional information before such date.

C. The Plan cannot base decisions regarding the hiring, compensation, termination, promotion, or other similar matters with respect to any individual (e.g., a claims adjudicator, medical expert, or vocational expert) upon the likelihood that the individual will deny a claim for benefits or support the Plan's denial of benefits on review.

D. Certain benefit determination notices and appeal notices may be required to be provided in a language other than English if ten percent or more of the population residing in the claimant's county are literate only in that other language. Further, the notices must include additional information such as information sufficient to identify the claim involved, the denial code and its corresponding meaning, any standard used in denying the claim, and a description of the available appeal and review processes.

*Legal Proceedings*

No action at law or in equity shall be brought by a claimant to recover a denied claim against the Plan before the exhaustion of remedies provided under the Claims Procedure provisions of the Plan. The claimant is not required to request a voluntary second-level appeal before bringing a lawsuit to recover a denied claim. However, a claimant may not bring any legal action to recover a denied claim, unless it is brought by the last day of the Calendar Year after the Calendar Year in which the claimant was provided with the initial written denial notice concerning the claim.

*No Interest*

The Plan shall not be required to pay interest on any claim for Plan benefits regardless of when paid.

*Unclaimed Property / Escheat*

If a check for the payment of Plan benefits is not negotiated within one year after the date it is issued, the check shall be dishonored.

### *PERMITTED AND REQUIRED USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)*

Subject to obtaining written certification pursuant to the Certification of the Plan Sponsor provision (see below), the Plan may disclose PHI to the Plan Sponsor provided that the Plan Sponsor does not use or disclose that PHI except for the following purposes:

A. To perform Administrative Functions for the Plan.

B. To obtain premium bids from insurance companies or other health plans for providing coverage under or on behalf of the Plan.

C. To modify, amend, or terminate the Plan.

Notwithstanding the provisions of the Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner inconsistent with 45 CFR § 164.504(f).

### *CONDITIONS OF DISCLOSURE*

The Plan Sponsor agrees to the following in regard to any PHI:

A. To not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

B. To ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.

C. To not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan.

D. To report to the Plan any known use or disclosure of the information that is inconsistent with the uses or disclosures permitted.

E. To make a Covered Person's PHI available when he or she requests access in accordance with 45 CFR § 164.524.

F. To make a Covered Person's PHI available when he or she requests an amendment to same, and to incorporate any amendments to that PHI in accordance with 45 CFR § 164.526.

G. To make available the information required to provide an accounting of disclosures of PHI to a Covered Person upon request in accordance with 45 CFR § 164.528.

H. To make its internal practices, books, and records relating to the use and disclosures of PHI received from the Plan available to the Secretary of the U.S.

Department of Health and Human Services in order to determine compliance by the Plan with the HIPAA privacy rules.

I. To return or destroy all PHI received from the Plan if the PHI is still maintained in any form, if feasible, and to retain no copies of such information when no longer needed for the purpose for which the disclosure was made. If such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

J. To ensure that the adequate separation between the Plan and the Plan Sponsor, required in 45 CFR § 164.504(f)(2)(iii), is satisfied and that terms set forth in the applicable provision below are followed.

To be compliant with the HIPAA security standards, the Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/termination information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, the Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI. The Plan Sponsor shall ensure that any agents (including Business Associates and subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The Plan Sponsor shall report to the Plan any security incident of which it becomes aware.

***CERTIFICATION OF PLAN SPONSOR***

The Plan shall disclose PHI to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth above.

***PERMITTED USES AND DISCLOSURE OF SUMMARY HEALTH INFORMATION***

The Plan may disclose Summary Health Information to the Plan Sponsor provided that the Plan Sponsor uses such Summary Health Information only for the following purposes:

A. To obtain premium bids from health plan providers to provide health coverage under the Plan.

B. To modify, amend, or terminate the Plan.

***ADEQUATE SEPARATION BETWEEN THE PLAN AND THE PLAN SPONSOR***

The Plan Sponsor will provide access to PHI to the employees or classes of employees listed in its HIPAA privacy policies and procedures. The Plan Sponsor will restrict the access to and use of PHI by these individuals to the Administrative Functions that the Plan Sponsor performs for the Plan. In the event any of these individuals do not comply with the provisions of the Plan relating to use and disclosure of PHI, the Plan Sponsor will impose reasonable sanctions as necessary, in its discretion, to ensure that no further noncompliance occurs. The Plan Sponsor will impose such sanctions progressively (e.g., an oral warning, a written warning, time off

without pay, and termination), if appropriate, and commensurate with the severity of the violation.

To comply with the HIPAA security rule, the Plan Sponsor shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the authorized employees or classes of employees have access to electronic PHI.

### *DISCLOSURE OF CERTAIN ENROLLMENT INFORMATION*

Pursuant to 45 CFR § 164.504(f)(1)(iii), the Plan may disclose information on whether an individual is enrolled in or has terminated from the Plan to the Plan Sponsor.

### *DISCLOSURE OF PHI TO OBTAIN STOP-LOSS OR EXCESS LOSS COVERAGE*

In accordance with the HIPAA privacy rules, the Plan Sponsor authorizes and directs the Plan to disclose PHI to stop-loss carriers, excess-loss carriers, or managing general underwriters for underwriting and other purposes in order to obtain and maintain stop-loss or excess-loss coverage related to benefit claims under the Plan.

### *OTHER USES AND DISCLOSURES OF PHI*

With respect to all other uses and disclosures of PHI, the Plan shall comply with the HIPAA privacy rules.

### *HYBRID ENTITY*

This provision only applies to the extent to which the Plan provides any non-health benefits such as (but not limited to) disability benefits or group term life insurance benefits. The Plan is a separate legal entity whose business activities include functions covered by the HIPAA privacy rules as well as functions not covered by those rules. As a result, the Plan is a "hybrid entity" as that term is defined in the HIPAA privacy rules. The Plan's covered functions are its health benefits ("health care component"). All other benefits are non-covered functions. Therefore, the Plan hereby designates that it shall only be a covered entity under the HIPAA privacy rules with respect to the health care component (the health benefits) of the Plan.

### *PARTICIPANT NOTIFICATION*

Participants shall be notified of the Plan's compliance with the HIPAA privacy rules in a Notice of Privacy Practices.

## PLAN ADMINISTRATOR

The Plan Administrator is charged with the administration of the Plan. The Plan Administrator shall have the discretionary authority to decide all questions of eligibility for participation and eligibility for benefit payments and to determine the amount and manner of payment of benefits. The Plan Administrator shall exercise its discretion in a uniform and consistent manner, based upon the objective criteria set forth in the Plan. Further, the Plan Administrator shall have the discretionary authority to construe and interpret the terms of the Plan, including the right to

remedy possible ambiguities, inconsistencies, or omissions. The Plan Administrator may delegate all or a portion of its duties under the Plan to one or more authorized officers and/or an administrative committee.

## AMENDMENTS AND TERMINATION

The Plan Sponsor reserves the right to amend or terminate this Plan at any time, in compliance with the following provisions:

A. The Plan Sponsor shall have the right to amend this Plan at any time, in whole or in part, to take effect retroactively or otherwise. No amendment may retroactively reduce claims for any Covered Expenses that were incurred before the amendment unless necessary to conform the Plan to the requirements of the Code, regulations issued under such statutes, and any other applicable laws or regulations.

B. The Plan Sponsor reserves the right at any time to terminate the Plan by action of the Board of Directors or other similar governing body of the Plan Sponsor.

In addition, the Plan shall automatically terminate upon the occurrence of any of the following events:

A. The liquidation or discontinuance of the business of the Plan Sponsor.

B. The adjudication of the Plan Sponsor as bankrupt.

C. A general assignment by the Plan Sponsor to or for the benefit of one or more of its creditors.

D. The merger or consolidation of the Plan Sponsor to another entity that is the surviving entity.

E. The consolidation or reorganization of the Plan Sponsor.

F. The sale of substantially all of the assets of the Plan Sponsor, unless the successor or purchasing entity adopts the Plan within 90 days thereafter.

If termination occurs, the Plan shall pay all benefits for Covered Expenses incurred before the termination date. Covered Persons shall have no further rights under the Plan.

## MISCELLANEOUS

### *FREE CHOICE OF PHYSICIAN*

The Covered Person shall have free choice of any legally qualified Physician or surgeon.

### *WORKERS' COMPENSATION NOT AFFECTED*

This Plan is not in lieu of, and does not affect, any requirement for coverage by Workers' Compensation Insurance.

### *CONFORMITY WITH LAW*

If any provision of this Plan is contrary to any law or regulation to which it is subject, that provision is deemed amended to conform to such law or regulation.

In accordance with guidance issued by the U.S. Department of Labor and the U.S. Department of Treasury (Joint Notice and Disaster Relief Notice 2020-01), certain deadlines mandated by the Plan will be extended in response to the COVID-19 pandemic beginning March 1, 2020 until 60 days after the announced end of the National Emergency Period (Outbreak Period). Specifically, the Plan must disregard the Outbreak Period when calculating these deadlines. However, in accordance with Disaster Relief Notice 2021-01, the Outbreak Period shall apply on an individual basis for each Covered Person and shall end the earlier of (a) one year from the date that the Covered Person was first eligible for relief, or (b) 60 days after the announced end of the National Emergency Period (the end of the Outbreak Period). In no event will an Outbreak Period deadline extension exceed one year.

### *FAILURE TO ENFORCE*

Failure to enforce any provision of this Plan does not constitute a waiver or otherwise affect the Plan Administrator's right to enforce such a provision at any other time, nor will such failure affect the right to enforce any other provision.

### *ENTIRE REPRESENTATION / NO ORAL MODIFICATIONS*

This single document sets forth the terms of the Plan and the Summary Plan Description and it supersedes all other documents. Any other descriptive or interpretive materials (such as benefit summaries) shall not change the terms of the Plan as set forth in this document. Further, the terms of the Plan may not be modified by any oral statements made by the Employer or any of its directors, officers, Employees, agents, or authorized representatives, including, but not limited to, the Claim Administrator.

### *NO VESTING*

There is no vested right to current or future benefits under this Plan. A Covered Person's right to benefits is limited to any Plan assets and to Covered Expenses incurred and submitted within the time limits set forth in the Claims Procedure provision and incurred and submitted before the earliest of the following:

A. An amendment to the Plan that limits or terminates such benefits.

B. Termination of the Plan.

C. Termination of coverage or participation.

### *NON-ASSIGNABILITY*

The benefits payable under the Plan to a Covered Person are specific to the Covered Person and may be received only by the Covered Person. No benefits of the Plan shall be assigned to any person, corporation, entity, or party except for assignment to the federal government in accordance with back-up withholding laws or except as provided in accordance with any assignment of rights as required by a state Medicaid program and in accordance with any state law that provides that the state has acquired the rights to payment with respect to a Covered Person. Any other attempted assignment shall be void. However, the Plan reserves the right to make payment of benefits, in its sole discretion, directly to a provider of services or the Covered Person. The Plan reserves the right, in its sole discretion, to refuse to honor the assignment of any claim to any person, corporation, entity, or party. This section shall not be interpreted to prevent direct billing for Covered Expenses by a provider to the Plan Administrator.

### *NO EMPLOYMENT RIGHTS*

The establishment and maintenance of this Plan shall not be construed as conferring any legal rights on any Employee to be continued in the employ of the Employer, nor shall this Plan interfere in any way with the right of the Employer to discharge any Employee.

### *COVERED PERSONS' RIGHTS*

Except as may be required by law, the establishment of this Plan and the Trust, if any, shall not be construed as giving any Participant or Dependent any equity or other interest in the assets, business, or affairs of the Employer; or the right to question or complain about any action taken by its officers, directors, or stockholders or about any policy adopted or followed by the Employer; or the right to examine any of the books and records of the Employer. The rights of all Participants and Dependents shall be limited to their right to receive payment of their benefits from the Plan when the same becomes due and payable in accordance with the terms of the Plan.

### *ACTS OF PROVIDERS*

Nothing contained in this Plan shall confer upon a Covered Person any claim, right, or cause of action, either at law or in equity, against this Plan for the acts of any provider (e.g., Physician) from which the Covered Person receives services or care while covered under this Plan.

### *RECOVERY OF OVERPAYMENT*

If the Plan pays benefits that should not have been paid under the Plan or pays benefits in excess of what should have been paid under the Plan, the Plan Administrator shall have the right to recover such payment or excess from any individual, insurance company, or other third-party payer, provider, or any other organization to or for whom the payment was made. Recovery may be in the form of an offset against future amounts owed under the Plan, by a lump-sum refund payment, or by any other method as the Plan Administrator, in its sole discretion, may require.

***ACCEPTANCE / COOPERATION***

Accepting benefits under the Plan means that the Covered Person has accepted the Plan's terms and shall be obligated to cooperate with the Plan Administrator's requests to help protect the Plan's rights and carry out its provisions.

## DEFINITIONS

Certain words and phrases used in this Plan are listed below, along with the definition or explanation of the manner in which the term is used for the purposes of this Plan. Where these terms are used elsewhere in the Plan with the meanings assigned to them below, the terms usually will be capitalized, and where these terms are used with their common, non-technical meanings, the terms usually will not be capitalized (except when necessary for proper grammar).

*ACTIVELY AT WORK*

The term "Actively at Work" means the active expenditure of time and energy in the service of the Employer. A Participant shall be deemed Actively at Work on each day of a regular paid vacation and on a regular non-working day on which the Participant is not totally disabled, if the Participant was Actively at Work on the last preceding regular working day.

*ADMINISTRATIVE FUNCTIONS*

The term "Administrative Functions" means activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. Administrative Functions include quality assurance, employee assistance, claims processing, auditing, monitoring, and management of carve-out-benefits, such as vision and dental. PHI for these purposes may not be used by or between the Plan or Business Associates in a manner inconsistent with the HIPAA privacy rules, absent an authorization from the individual. Administrative functions specifically do not include any employment-related functions.

*ANNUAL OPEN ENROLLMENT PERIOD*

The term "Annual Open Enrollment Period" means the period during the year for making elections under the Plan. The beginning and ending dates of each Annual Open Enrollment Period shall be determined by the Employer and communicated to Participants.

*BUSINESS ASSOCIATE*

The term "Business Associate" means a person or entity who does the following:

A. Performs or assists in performing a Plan function or activity involving the use and disclosure of PHI (including claims processing or administration, data analysis, underwriting, etc.).

B. Provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.

*CALENDAR YEAR*

The term "Calendar Year" means a period of time beginning with January 1 and ending on the following December 31.

*CHANGE IN STATUS*

The term "Change in Status" means any of the following:

A. An event that changes the Employee's legal marital status, including marriage, death of the Employee's spouse, divorce, legal separation (if recognized by the state in which the individuals reside), and annulment.

B. An event that changes the number of an Employee's dependents, including birth, adoption, placement for adoption, and death of a dependent.

C. An event affecting the employment status of the Employee, the Employee's spouse, or the Employee's dependent; including termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence, a change in work site, and any other change in employment status that affects an individual's eligibility for benefits.

D. An event that causes an Employee's dependent to satisfy or cease to satisfy the requirement(s) for coverage owing to the attainment of a specified age, student status, or any similar circumstance.

E. A change in the place of residence of the Employee, the Employee's spouse, or the Employee's dependent.

*CLAIM ADMINISTRATOR*

The term "Claim Administrator" means the person or firm, if any, retained by the Plan Administrator to handle the processing, payment, and settlement of benefit claims and other duties specified in a written administration agreement. If there is no Claim Administrator (for any reason, including circumstances caused by the termination or expiration of the Administration Agreement with the initial Claim Administrator), or if the term is used in connection with a duty not expressly assumed by the Claim Administrator in a signed writing, the term shall mean the Plan Administrator.

*CLOSE RELATIVE*

The term "Close Relative" means the spouse, parent, brother, sister, child, or in-laws of a Covered Person.

*COBRA*

The term "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (see Section 4980B of the Code and Sections 601 et seq. of the Employee Retirement Income Security Act of 1974 [ERISA], as amended). See Consolidated Omnibus Budget Reconciliation Act of 1985.

*CODE*

The term "Code" means the Internal Revenue Code of 1986, as amended.

*COINSURANCE*

The term "Coinsurance" means a Covered Person's share of the cost of a Covered Expense. Coinsurance is expressed as a percentage (for example, 20%) and typically applies after the Deductible (if any) has been satisfied.

*CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985*

The term "Consolidated Omnibus Budget Reconciliation Act of 1985" means federal legislation that gives workers and their families who lose their health benefits the right to choose to continue the benefits provided by their group health plan for limited periods of time under certain circumstances. In the context of a governmental employer, this term means the parallel continuation coverage provisions of the Public Health Service Act. See COBRA.

*COSMETIC PROCEDURE*

The term "Cosmetic Procedure" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness, injury, or disease.

*COVERED EXPENSES*

The term "Covered Expenses" means expenses incurred by a Covered Person for any medically necessary treatments, services, or supplies that are not specifically excluded from coverage elsewhere in this Plan. Covered Expenses are incurred on the date that any medically necessary treatments, services, or supplies are provided to a Covered Person.

*COVERED PERSON*

The term "Covered Person" means any person meeting the eligibility requirements for coverage as specified in this Plan and who is properly enrolled in the Plan. This term includes Participants and their eligible Dependents.

*DEDUCTIBLE*

The term "Deductible" means a specified dollar amount of Covered Expenses that must be incurred during a year before any other Covered Expenses can be considered for payment at the percentages stated in the Schedule of Benefits and in this Plan.

*DEPENDENT*

The term "Dependent" means the following:

A. The Participant's legal spouse. The spouse must have met all of the requirements of a valid marriage contract in the state of marriage of the parties.

B. A child who meets all of the following conditions:

1. May be identified in one of the following categories:

a. The Participant's natural child, the Participant's stepchild, the Participant's legally adopted child, or a child who is being placed for adoption with the Participant.

b. A child who is under the legal guardianship of the Participant and could be considered a "dependent" of the Participant for tax exemption purposes under Section 152 of the Code.

c. A child to whom the Participant is obligated to provide health care coverage under an order or judgment of a court of competent jurisdiction and could be considered a "dependent" of the Participant for tax exemption purposes under Section 152 of the Code.

2. Is less than 26 years of age. Coverage will continue through the end of the month in which the child's 26th birthday occurs. The age requirement above is waived for any child who is developmentally disabled or who has a physical handicap(s) before age 26 who is incapable of self-sustaining employment, and who could be considered a "dependent" of the Participant for tax exemption purposes under Section 152 of the Code. Proof of incapacity must be furnished to the satisfaction of the Plan Administrator upon request, and the Plan Administrator may request additional proof from time to time.

C. A child for whom the Participant is obligated to provide health care coverage under a QMCSO, notwithstanding the above.

***NOTE:*** If both parents are Employees of the Employer, children will be covered under this Plan as Dependents of only one parent.

The Participant may be asked to certify the status of the persons for whom the Participant is claiming Dependent status, and benefits shall be terminated and the Participant shall be asked to reimburse the Plan if it is discovered that he/she has provided false information.

The term "Dependent" excludes these situations:

A. A spouse or former spouse who is legally separated or divorced from the Participant, pursuant to a valid separation or divorce in the state granting the separation or divorce.

B. Any person who is covered under this Plan as an individual Participant.

C. Any person who would otherwise qualify as a Dependent, but who is not properly enrolled in the Plan.

*DEPENDENT COVERAGE*

The term "Dependent Coverage" means coverage under the Plan for benefits payable as a consequence of an illness or injury of a Dependent or for routine preventive care for a Dependent.

*EMPLOYEE*

The term "Employee" means a common-law employee of the Employer. An independent contractor is not an Employee. Further, a leased employee within the meaning of Code Section 414(n) is not an Employee. If an independent contractor or a leased employee is subsequently characterized as a common-law employee of the Employer, that person shall not be eligible to participate in the Plan for any time period before the date on which the determination is made that that person is a common-law employee of the Employer.

*EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974*

The term "Employee Retirement Income Security Act of 1974" means a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. See ERISA.

*EMPLOYER*

The term "Employer" means **ANDREWS UNIVERSITY**.

*ERISA*

The term "ERISA" refers to the Employee Retirement Income Security Act of 1974, as amended, Section 3(1), 29 U.S.C. §1002(1). See Employee Retirement Income Security Act of 1974.

*FAMILY*

The term "Family" means a Participant and any Dependent(s).

*FAMILY AND MEDICAL LEAVE ACT OF 1993*

The term "Family and Medical Leave Act of 1993" means a federal law that provides certain employees with unpaid, job-protected leave each year, the duration of which is pre-determined

by the federal government. It also requires that their group health benefits be maintained during the leave. See FMLA.

*FMLA*

The term "FMLA" means the Family and Medical Leave Act of 1993, Public Law 103-3 (February 5, 1993), 107 Stat. 6 (29 U.S.C. 2601 et seq.). See Family and Medical Leave Act of 1993.

*FULL-TIME EMPLOYMENT*

The term "Full-Time Employment" means a basis by which a Participant is employed and is compensated for services by the Employer for at least the number of hours per week stated in the eligibility requirements of the Schedule for Eligibility and Participation. The work may occur either at the usual place of business of the Employer or at another location required or approved by the Employer. A full-time Employee who is absent from work because of a health condition is considered to work in Full-Time Employment for purposes of satisfying any waiting period set forth in the eligibility requirements of the Schedule for Eligibility and Participation.

*HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996*

The term "Health Insurance Portability and Accountability Act of 1996" means a federal law that limits the use of pre-existing condition exclusions, waiting periods, and health status exclusions; eliminates certain discriminatory exclusions, such as for self-inflicted injuries; and promulgates administrative simplification provisions. See HIPAA.

*HIPAA*

The term "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended (Public Law 104-191). See Health Insurance Portability and Accountability Act of 1996.

*IN-NETWORK PROVIDERS*

The term "In-Network Providers" means a group of Physicians, dental doctors, oral surgeons, and other medical or dental providers that have agreed to provide health care at discounted fees in accordance with the Utilization of In-Network Dental Providers section.

*LIFETIME*

The term "Lifetime" means the time a person is actually a Covered Person in this Plan, including any amendment or restatement of this Plan. The term "Lifetime" is not intended to suggest benefits before the effective date of an individual or after the termination of an individual or of the Plan.

*MEDICARE*

The term "Medicare" means the programs established by Title I of Public Law 89-98, as amended, entitled "Health Insurance for the Aged Act," and that includes parts A and B of Subchapter XVIII of the Social Security Act as amended from time to time.

*MOTOR VEHICLE*

The term "Motor Vehicle" means a car or other vehicle, including a trailer, operated or designed for operation upon a public highway by power other than muscular power that has more than two wheels. Motor Vehicle does not include a motorcycle, a moped, or any "off-road vehicle" (ORV) or "all-terrain vehicle" (ATV).

*OBRA 1993*

The term "OBRA 1993" means the Omnibus Budget Reconciliation Act of 1993, Public Law 103-66 (August 10, 1993). See Omnibus Budget Reconciliation Act of 1993.

*OMNIBUS BUDGET RECONCILIATION ACT OF 1993*

The term "Omnibus Budget Reconciliation Act of 1993" means a federal law that adds a provision to COBRA's tax code rules regarding pediatric vaccine coverage. See OBRA 1993.

*ORTHOPTICS; VISION THERAPY*

The terms "Orthoptics" and "Vision Therapy" mean the science of correcting defects in a person's simultaneous use of both eyes (binocular vision) through administration of vision therapy aids and/or eye muscle exercises.

*OUT-OF-NETWORK PROVIDERS*

The term "Out-of-Network Providers" means a group of Physicians, dental doctors, oral surgeons, and other medical or dental providers that do not participate within a plan's contracted network and do not provide health care at discounted fees.

*PARTICIPANT*

The term "Participant" means an Employee or former Employee who meets the eligibility requirements and who is properly enrolled in the Plan.

*PARTICIPANT COVERAGE*

The term "Participant Coverage" means coverage included under this Plan providing benefits payable as a consequence of an injury or illness of a Participant or for routine preventive care for a Participant.

*PART-TIME EMPLOYMENT*

The term "Part-Time Employment" means a basis by which a Participant is employed and is compensated for services by the Employer for at least the number of hours per week stated in the

eligibility requirements of the Schedule for Eligibility and Participation. The work may occur either at the usual place of business of the Employer or at another location required or approved by the Employer. A part-time Employee who is absent from work because of a health condition is considered to work in Part-Time Employment for purposes of satisfying any waiting period set forth in the eligibility requirements of the Schedule for Eligibility and Participation.

*PHI*

See Protected Health Information.

*PHYSICIAN*

The term "Physician" means a legally licensed medical or dental doctor, oral surgeon, or optometrist, to the extent that he/she, within the scope of his/her license, is permitted to perform services provided in this Plan.

*PLAN*

The term "Plan" means the Andrews University Employee Benefit Plan, as periodically amended.

*PLAN ADMINISTRATOR*

The term "Plan Administrator" means **ANDREWS UNIVERSITY**, who is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services.

*PLAN SPONSOR*

The term "Plan Sponsor" means **ANDREWS UNIVERSITY**.

*PLAN YEAR*

The term "Plan Year" means the 12-month period that begins on July 1 and ends on the following June 30. This time period is used for purposes of determining annual benefit-based accumulators (e.g., Deductibles), Form 5500 reporting (if required), compliance with the Patient Protection and Affordable Care Act (PPACA), as amended, and compliance with other laws impacting the Plan.

*PROTECTED HEALTH INFORMATION*

The term "Protected Health Information" means information that is created or received by the Plan or a Business Associate and relates to the past, present, or future physical or mental health or condition of a Covered Person, the provision of health care to a Covered Person, or the past, present, or future payment for the provision of health care to a Covered Person. Also, the information identifies the Covered Person or there is a reasonable basis to believe the information can be used to identify the Covered Person (whether living or deceased). The following components of a Covered Person's information will enable identification:

- Names
- Street address, city, county, precinct, ZIP code
- Dates directly related to a Covered Person's receipt of health care treatment, including birth date, health facility admission and discharge date, and date of death
- Telephone numbers, fax numbers, and electronic mail addresses
- Social security numbers
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers and serial numbers, including license plate numbers
- Device identifiers and serial numbers
- Web Universal Resource Locators (URLs)
- Biometric identifiers, including finger and voice prints
- Full face photographic images and any comparable images
- Any other unique identifying number, characteristic, or code

*QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)*

The term "Qualified Medical Child Support Order (QMCSO)" means an order pursuant to OBRA 1993 and applicable state law that requires the Plan to provide health coverage to a participating Employee's child. A QMCSO may either be obtained under state domestic relations law or may be initiated by a court or state administrative agency pursuant to applicable state law. The Plan Administrator shall develop procedures to determine whether an order submitted to the Plan constitutes a QMCSO pursuant to OBRA 1993 and applicable state law.

*SPECIAL ENROLLMENT PERIOD*

The term "Special Enrollment Period" means the period for an individual with special enrollment rights to make enrollment elections under the Plan. The circumstances under which an individual has special enrollment rights are described in the Participant Enrollment and Dependent Enrollment sections and are prescribed by HIPAA and federal regulations issued pursuant to HIPAA.

*SUMMARY HEALTH INFORMATION*

The term "Summary Health Information" means information that may be individually identifiable health information. It summarizes the claims history, claims expenses, or types of claims experienced by individuals for whom Plan Sponsor has provided health benefits under the Plan. The information described in 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information may be aggregated to the level of five-digit ZIP codes.

*USUAL AND CUSTOMARY*

The term "Usual and Customary" refers to the designation of a charge as being the usual charge made by a Physician or other provider of services, supplies, or equipment that do not exceed the general level of charges made by other providers rendering or furnishing such care or treatment

within the same area. The term "area" in this definition means a county or other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any complications or unusual circumstances that require additional time, skill, or expertise.

## NO RIGHTS UNDER ERISA

The Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA, does not apply to this Plan. The fact that the Plan may, in some respects, conform to the requirements of ERISA, or include provisions often found in plans that are subject to ERISA, shall not be interpreted or construed to mean that the Plan is intended to comply with ERISA, or that Employees, Participants, or beneficiaries have any rights under ERISA. The preceding statement also pertains to other federal laws that do not apply to the Plan.

## RULES OF CONSTRUCTION

This Plan shall be construed in accordance the Code, and, where not pre-empted, the laws of the state of Michigan.

The use of the singular includes the plural where applicable and vice versa. The headings do not limit or extend the provisions of the Plan. Capitalized terms, except where capitalized solely for grammar, have the meaning provided in the Plan. Errors cannot cause the Plan to provide a benefit that a Covered Person is not otherwise entitled to under the Plan. If a provision is unenforceable in a legal proceeding, the provision shall be severed solely for purposes of that proceeding and the remaining provisions of the Plan shall remain in full force.

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Andrews University has caused this amended and restated Plan to be effective as of 12:01 a.m. local time, July 1, 2022.