HOPE COLLEGE EMPLOYEE BENEFIT PLAN

Plan No. 501

PLAN DOCUMENT and SUMMARY PLAN DESCRIPTION

Amended and Restated as of July 1, 2020

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INTRODUCTION

Hope College (the "**Employer**") amends and restates the Hope College Benefit Plan (the "**Plan**") effective as of July 1, 2020. The Plan is sponsored and maintained for the benefit of the Employer's eligible employees and their eligible dependents.

The Plan allows eligible employees to choose benefits from among the following benefit programs (the "Benefit Programs"):

A "Medical/Rx Program

A "Health Savings Account Contributions Program" (the "HSA Contributions **Program**") allows you to make tax-free contributions to an HSA if you participate in an HDHP offered under this Plan's Medical/Rx Program.

Some of the Benefit Programs are "**Insured**," which means the Employer pays premiums to insurance companies that, in turn, pay for the benefits under insurance policies or contracts. Other Benefit Programs are "**Self-Insured**," which means the benefits are paid from the Employer's general assets and are not provided through an insurance contract. <u>Appendix B</u> (Benefit Program Information Chart) at the end of this document indicates the type of funding for each Benefit Program.

For each Insured Benefit Program:

This document and the insurance contract or policy listed on the attached <u>Appendix A</u> (Plan Documents Chart) ("**Insurance Contract**") serve as the official Plan document. If a conflict arises between the terms of this document and the Insurance Contract, the terms of the Insurance Contract will control.

The insurer-prepared booklets, summaries, and/or certificates that describe the benefits available under the Benefit Program and that are listed on the attached <u>Appendix A</u> (Plan Documents Chart) ("**Booklets**"), together with this document, make up the summary plan description. If a conflict arises between the terms of this document and a Booklet, the terms of the Booklet will control. If a conflict arises between a Booklet and the Insurance Contract, the terms of the Insurance Contract will control.

For each Self-Insured Benefit Program, this document, along with applicable benefit certificates, booklets and/or summaries listed on the attached <u>Appendix A</u> (Plan Documents Chart) ("**Booklets**"), serve as the Plan document and summary plan description. If a conflict arises between the terms of this document and a Booklet, the Booklet will control.

The provisions of this Plan apply uniformly to all Participants, except as otherwise specifically stated herein. Please read these documents carefully and keep them with your personal records for future reference.

Where we define a term in this document, it also appears in bold print and in quotation marks. For your convenience, an Index of Defined Terms appears at the end of this document.

If you have any questions about a Benefit Program or the Plan in general, please contact the Human Resources Department at (616) 395-7811.

OBTAINING AND CHANGING COVERAGES

EMPLOYEE ELIGIBILITY

Full-Time Employee Eligibility

You may participate in all Benefit Programs under the Plan if you are a Full-Time Employee and you are not classified by the Employer in a position that is excluded from participation in the Plan in the section below titled "Ineligible Individuals."

You are a "Full-Time Employee" if you meet either of the following requirements:

you are regularly scheduled to work at least 1,560 hours per year; or

you are regularly scheduled to work fewe

reimbursement under the Health Care FSA Program for health care expenses incurred by your family members (see "Health Care FSA Program" beginning on page 22) and you may be eligible to receive reimbursement under the Dependent Care FSA Program for expenses incurred for the care of a family member (see "Dependent Care FSA Program" beginning on page 18).

The Plan Administrator may require you to show proof that a dependent meets the eligibility criteria. You must notify the Plan Administrator, in writing, of any change in status that results in a dependent no longer being an Eligible Dependent (e.g., your Spouse in the event of a divorce). The Plan has a right to recover from you any payments made by the Plan on behalf of an individual who is not an Eligible Dependent (see "Overpayments" beginning on page 71).

Definitions "Spouse

You have notified the Plan Administrator in writing of the condition before the time

Only you, and not your Eligible Dependents, may make Benefit Program elections. If you have properly enrolled in any Benefit Program, you are a "Participant" in the Plan. Any Eligible Dependents properly enrolled in the Plan are "Covered Dependents".

Unless otherwise specified in the enrollment materials, an applicable Insurance Contract or in the applicable Booklets, you must enroll yourself in a Benefit Program in order to also enroll your Eligible Dependents in that Benefit Program.

Open Enrollment

Each year the Employer establishes an 'Open Enrollment Period " during which you can make new benefit elections for the upcoming Plan Year. To make your elections, you must complete the enrollment process as directed by the Plan Administrator prior to the end of the Open Enrollment Period.

The choices you make during the Open Enrollment Period will be effective on the first day of the upcoming Plan Year. Once the Plan Year begins, your choices are irrevocable and will remain in effect without any changes permitted through the remainder of the Plan Year, unless you are entitled to a Special Enrollment Period or a Change Event occurs. You may, however, change your Employee Contributions under the HSA Contributions Program on a prospective basis at any time.

If the Open Enrollment Period occurs while you are on an Employer-approved leave during which your benefits continue, you will be contacted and allowed to make an election during the Open Enrollment Period. If the Open Enrollment Period occurs while you are on an Employer-approved leave during which your benefits do <u>not</u> continue, you will be allowed to make an election for the new Plan Year when you return fr om your leave as long as you are eligible to participate upon your return.

If you enroll in the Medical/Rx, Dental, Vision, Dependent Care FSA, Health Care FSA, or HSA Contributions Programs, you will be automatically enrolled in the Pre-Tax Payment Program. However, if you are enrolled in the Orange Plan under the Medical/Rx Program because you met the eligibility criteria described in the sect ion titled "Additional Eligibility Rules for the Medical/Rx Program" beginning on page 4, you are not eligible to pay for that coverage through the Pre-Tax Payment Program, and you must pay for your coverage on an after-tax basis.

Failure to Timely Enroll

Initial Enrollment Period

Open Enrollment Period

If you are an eligible Full-Time Employee and you fail to properly enroll during an Open Enrollment Period, you will be deemed to have elected, and will be automatically enrolled in, Basic Coverage as well as the same level of coverage under the Medical/Rx, Dental, and Vision Programs, and any voluntary coverage under the Life/AD&D Insuranwisio3id Long-Term Disability Programs, as you have for the current Plan Year. You will be deemed to have declined coverage under all

A change in your work schedule or that of your dependent (e.g., from full-time to parttime);

A change in your residence or that of your dependent that limits network access; or

A dependent satisfying, or ceasing to satisfy, requirements for dependent status under a Benefit Program (e.g., because of age or marriage).

Except with respect to the Health Care FSA Program, the following are also Change Events, regardless of whether or not the change causes you or a dependent to become eligible or ineligible for coverage:

A change in the availability of benefit options or coverage under any of the Benefit Programs (e.g., a medical option is added to or deleted from the Medical/Rx Program);

A change in coverage under another employer's plan resulting from either: (i) an election made during an open enrollment period under the other employer's plan that relates to a period of coverage that is different from the Plan Year for this Plan (e.g., your Spouse's open enrollment period is in January and your Spouse changes coverage), or (ii) a mid-year election change permitted under the other employer's plan;

A significant increase or decrease in the cost of coverage during the Plan Year; and

A loss of coveecal opeo.2(cal/R8D-.0005 Tc.1252 Tw.5(f3signific6rage une)lowid)113.ucavior4her

Additional Change Events for Medical/Rx Program

In addition to the above Change Events, you may also change your elections under the Medical/Rx Program:

if (i) you have a change in employment status that results in a change in work schedule from one in which you were reasonably expected to average 30 Hours of Service per week to a schedule in which you will be reasonably expected to average fewer than 30 Hours of Service per week without losing eligibility to participate in this Plan and (ii) you intend to enroll in another plan that provides minimum essential coverage that will become effective no later than the first day of the second month following the month in which your coverage under this Plan is revoked; or

if (i) you become eligible to enroll in a health plan offered through a Health Insurance Marketplace established under the Affordable Care Act ("**Marketplace**") either because of a special enrollment right or during the Marketplace's annual open enrollment period and (ii) your new coverage under that plan will become effective no later than the day after your coverage under this Plan ends.

In either instance, you will be required to certify your intent to enroll in other coverage.

Additional Change Event for Dependent Care FSA Program

In addition to the above Change Events, you may also change your elections under the Dependent Care FSA Program if there is a change in your dependent care provider or a significant increase or decrease in the cost of dependent care.

Consistency Rule

Your election change must be consistent with the Change Event that affects your coverage under a Benefit Program. For example:

If one of your Covered Dependents no longer meets the requirements for coverage, you can cancel coverage for that Covered Dependent, but you could *not* cancel coverage for your other Covered Dependents.

If you have single coverage and you marry, you can elect family coverage.

If your Spouse enrolls in coverage under his or her employer's plan, you can drop coverage for your Spouse under this Plan.

If your dependent care provider changes, you can change your elections relating to the Dependent Care FSA Program but you could *not*

provide additional documentation for certain Change Events (e.g., a marriage certificate if you wish to add a new Spouse to your benefits coverage). The change request must be filed on or before the date that is 30 days after the date of the Change Event. The change in coverage generally will be effective as of the first payro II period following notification, or as soon as administratively possible thereafter. However, if the Change Event is birth or adoption of an

You fail to meet the eligibility requirements or conditions of the Benefit Program;

For an Insured Benefit Program, the effective date for termination of coverage when the group Insurance Contract terminates;

You commit, or attempt to commit, fraud against the Plan or have been dishonest about a material matter affecting eligibility for benefits. In the case of fraud or intentional misrepresentation of a material fact, *coverage may be retroactively terminated*;

The Employer terminates the Benefit Program.

Also, if you fail to timely make any required Employee Contributions, the Plan may terminate your coverage retroactive to the last day of the coverage period for which you have paid.

If you are eligible for COBRA or USERRA Continuation Coverage, you may elect to continue your health coverage. Special rules apply to the timing of any required payments for COBRA or USERRA Continuation Coverage. (See "COBRA Continuation Coverage" and "Military Leave

VISION PROGRAM

For a description of the Vision Program benefits, please refer to the Booklets provided by the Claims Administrator listed in <u>Appendix B</u> (Benefit Program Information Chart).

LONG-TERM DISABILITY PROGRAM

For a description of the Long-Term Disability Program benefits, including optional benefits available for purchase under the Program, please refer to the Booklet provided by the Claims Administrator listed in <u>Appendix B</u> (Benefit Program Information Chart).

LIFE/AD&D INSURANCE PROGRAM

For a description of the Life/AD&D Insurance Program benefits, including optional benefits available for purchase under the Program, please refer to the applicable Booklet provided by the Claims Administrator listed in <u>Appendix B</u> (Benefit Program Information Chart).

GROUP TRAVEL ACCIDENT PROGRAM

For a description of the Group Travel Accident Program benefits, please refer to the Booklet provided by the Claims Administrator listed in <u>Appendix B</u> (Benefit Program Information Chart).

EAP

For a description of the EAP benefits, please refer to the Booklet provided by the Claims Administrator listed in <u>Appendix B</u> (Benefit Program Information Chart).

PRE-TAX PAYMENT PROGRAM

The Pre-Tax Payment Program allows you to pay for benefits under the following Benefit Programs on a tax-free basis: Medical/Rx Program coverage obtain other than by reason of meeting the eligibility criteria de scribed in the section titled "Additional Eligibility Rules for Medical/Rx Program" beginning on page 4, and Dental, Vision, Health Care FSA, and Dependent Care FSA Programs. Employee Contributions for **a** other coverage will be paid on an after-tax basis.

To the extent Employee Contributions are required for benefits you elect under the Benefit Programs subject to the Pre-Tax Payment Program, you agree to have the Employer reduce your compensation to cover the cost of those benefits. Because your compensation is reduced, the amount of your federal payroll and Social Security taxes, as well as most state and municipal taxes, will also be reduced.

The Pre-Tax Payment Program may not be used to purchase individual health plan coverage or coverage obtained through the Marketplace.

COBRA Premiums

For so long as you continue to earn compensation from the Employer, you may also pay any COBRA or USERRA Continuation Coverage premiums for coverage provided under this Plan tax free.

If you and your Spouse divorce, COBRA premiums to continue coverage for your former Spouse may not be paid on a pre-tax basis under this Pre-Tax Payment Program.

DEPENDENT CARE FSA PROGRAM

The Dependent Care FSA Program is designed to help you make tax-free payments for Eligible Dependent Care Expenses. Because the contributions you make under the Dependent Care FSA Program are made on a pre-tax basis, your taxable income will be reduced and, therefore, your federal payroll and Social Security taxes, as well as most state and municipal taxes, will be reduced. Because you will pay fewer taxes, your net take-home pay will be increased.

Example:

You are married and you and your Spouse each earn \$30,000 per year and you are in the 25% tax bracket. You estimate that your yearly Eligible Dependent Care Expenses will be \$3,000. So, you choose to contribute \$3,000 to your Dependent Care FSA.

	Using Dependent Care <u>FSA Program</u>	Not Using Dependent Care FSA <u>Program</u>
Your Gross Pay (You and Your Spouse)	\$60,000	\$60,000
Your Pre Tax Dependent Care Expenses	3,000	<u>N/A</u>
Your Taxable Income	57,000	60,000
Your Income Taxes (25%)	14,250	15,000
Your Post Tax Dependent Care Expenses	0	3,000
Your Net Take Home Pay	\$42,750	\$42,000
Your Tax Savings	\$750	N/A

Dependent Care Flexible Spending Account

If you enroll in the Dependent Care FSA Program for a Plan Year, the Plan Administrator will establish a dependent care flexible spending account ("**Dependent Care FSA**") for you for the Plan Year. Your Dependent Care FSA will be credited each pay period with the Employee Contribution amount you authorized.

Your Dependent Care FSA is for bookkeeping purposes only. The amounts credited to your Dependent Care FSA are not assets that belong to you.

Annual Contribution Amount

The maximum amount you may contribute to your Dependent Care FSA each Plan Year is the least of:

Your earned income from employment,

Your Spouse's earned income from employment, or

\$5,000 annually (\$2,500 if married filing separately).

If your Spouse has not earned any income from employment, but is a Full-Time Student or disabled and unable to care for himself or herself, your Spouse will be assumed to have earned \$250 a month if you claim reimbursement for the care of one Qualifying Individual, or \$500 a month if you claim reimbursement for the care of two or more Qualifying Individuals. A "Full-Time Student" means an individual who is considered a full-time student by a school during at least five calendar months during the taxable year. For this purpose, a school includes a high school; college; university; or technical, trade and mechanical school. It does not include an on-the-job training course, correspondence school, or school offering courses only on the Internet.

If the amount of your or your Spouse's earned income changes during the Plan Year so that your authorized contribution amount exceeds the maximum amount as stated above, you should immediately notify the Plan Administrator so that your authorized contribution amount can be reduced.

Amount That Can Be Reimbursed to Participants

You will only be reimbursed for Eligible Dependent Care Expenses you incur during the Plan Year for which you elected to be covered under the Dependent Care FSA Program.

Unlike the Health Care FSA Program, the Dependent Care FSA Program reimburses you for a Claim only to the extent that you have a balance in your Dependent Care FSA. If the balance in your Dependent Care FSA is insufficient to pay a Claim in full, the remainder of the Claim will be carried over and paid when the balance in your Dependent Care FSA is sufficient. No reimbursement is available before the Eligible Dependent Care Expense is incurred.

An expense is considered incurred on the date the services are performed and not when you are billed or make a payment.

Eligible Dependent Care Expenses

The amount credited to your Dependent Care FSA may only be used to pay for the Eligible Dependent Care Expenses of a Qualifying Individual.

A "Qualifying Individual" is defined as:

Your child under the age of 13 who is considered your dependent for federal income tax purposes; or

Your Spouse or dependent for federal income tax purposes (regardless of age) who is physically or mentally incapable of self-care, resides with you for at least one-half of your tax year, and regularly spends at least eight hours a day in your home. This rule also applies to a person who otherwise meets these requirements but who is not your tax dependent only because: he or she received gross income of \$4,000 or more; he or

she filed a joint return; or you, or your Spouse if filing jointly, could be claimed as a dependent on someone else's tax return.

If you are a parent who is divorced, legally separated, or separated under a written separation agreement, or if you lived apart from your Spouse at all times during the last six months of the calendar year, your child will be considered a Qualifying Individual if:

the child is under the age of 13 or is physically or mentally incapable of self-care;

the child is in your, the child's other parent's, or both of your custody for more than one-half of the calendar year;

the child received over one-half of his or he

Related expenses that are not directly for the care of an Eligible Dependent, such as

Federal Dependent Care Tax Credit

You are not eligible to receive both the federal dependent care tax credit and reimbursement under the Dependent Care FSA Program for the same expense. Before enrolling in the Dependent Care FSA Program, you should consider whether reimbursement under the Dependent Care FSA Program is more advantageous to you than the maximum federal dependent care tax credit. See IRS Publication 503 for more information.

Provider Information

When you submit your first Claim each year, you must provide the Claims Administrator with

Example:

You earn \$30,000 per year and you are in the 25% tax bracket. You estimate that your yearly Eligible Health Care Expenses will be \$1,

Amount Available for Reimbursement

Unlike the Dependent Care FSA Program, the Health Care FSA Program reimburses you for a Claim even if the balance in your Health Care FSA

Medical/Rx, dental, or vision expenses;

Prescription drugs;

Over-the-counter medications obtained with a doctor's prescription (e.g., antacids,

Expenses submitted after the applicable Claims deadline described in "Claims Under Group Health Plans: Medical/Rx, Dental, Vision, EAP, and Health Care FSA Programs" beginning on page 30.

Amounts in your Health Care FSA can only be used to pay for Eligible Health Care Expenses and not for Eligible Dependent Care Expenses.

Any reimbursement paid for an expense that is not an Eligible Health Care Expense will be subject to income taxes as applicable.

Carry-Over Amounts

You are permitted to carry over into the following Plan Year unspent funds, up to a maximum amount ("**Carry-Over Amount**") as long as you remain eligible to participate in the Health Care FSA Program and you elect to contribute to the Health Care FSA Program for that following Plan Year. The maximum Carry-Over Amount will be automatically increased to an amount equal to 20 percent of the Code's maximum health FSA salary reduction contribution amount for the Plan Year from which the amounts are carried over. Thus, the maximum unused amount that can be carried over from the Plan Year beginning in 2020 to the Plan Year beginning in 2021 is \$550. Unused Carry-Over Amounts attributable to one Plan Year will be forfeited at the end of the following Plan Year.

Forfeiture of Amounts in Your Health Care FSA

If you join the Plan after the start of the year and have not been previously covered under a high deductible health plan, the amount you may contribute without restriction is also prorated for the number of months you are covered by the HDHP option (and are otherwise eligible to contribute to an HSA). However, the IRS has a special rule that allows you to fund your HSA up to the annual contribution limit for the calend ar year if you are covered by an HDHP in December of that calendar year. To take advantage of this rule, you are required to remain covered under a high deductible health plan (and not otherwise be disqualified from contributing to an HSA) until the end of the *following* calendar year. If you fail to remain HSA-eligible throughout the following calendar year, you would have to pay income taxes, plus an additional 10% penalty tax, on the contributions above your prorated contribution limit, unless you lose your HSA eligibility based on disability or death.

You are responsible for determining whether you are eligible to contribute to an HSA each month and for adjusting your HSA contributions accordingly. For more information, you should read IRS Publication 969.

Changing HSA Contributions

You can elect to begin or end contributions, or increase or decrease contributions, to your HSA at any time. These changes will not affect your prior contribution s, but only contributions you make going forward. Your change will go into effect with the ne xt payroll period that begins after you have successfully submitted your election change, or as soon thereafter as administratively feasible.

Recording Contributions

Because you are the owner of your HSA, you are responsible for keeping track of how much has been deposited into your account. The Employer will keep track of HSA contributions made through this Plan; however, you will be responsible for keeping track of contributions made

those described in the Booklets, the Booklets will control. If the Bookle ts for a Benefit Program do not contain claims procedures, the procedures described in this section for that Benefit Program will apply.

General Rules A "Claim "

Deadline for Post-Service Claims Under Medical/Rx, Dental, Vision, and EAP Programs You are encouraged to submit your Post-Service Claims under the Medical/Rx, Dental, Vision, and EAP Programs as soon as possible after you intur the expense. Unless otherwise specified in the applicable Insurance Contracts or Booklets, Post-Service Claims under these Programs must be submitted within 12 months of the date the expense was incurred.

If your Concurrent Care Claim is for the extension of a previously approved course of treatment, the Claims Administrator will notify you of its determination (whether adverse or not) within 24 hours after receipt of the Claim.

Post-Service Claim

The Claims Administrator is not required to notify you of its determination for a Post-Service Claim unless the Claim is denied. If a Post-Service Claim is denied, the Claims Administrator will provide you with a Notice of Initial Claim Denial within a reasonable period of time, but not later

include an explanation of the Plan's internal and external appeal procedures, including information about how to initiate an appeal and the applicable time limits; and a statement that you have a right to bring a civil action in court if your Claim is denied after you have exhausted the required appeal procedures;

provide contact information for an office of health insurance consumer assistance or a health insurance ombudsman program, if such a service has been established in your state.

Special Rules for Urgent Care Claims

The notice of initial claim denial for an Urgent Care Claim may be provided orally, with a written or electronic notice to follow within three days. In addition to the information listed above, the notice of initial claim denial for an Urgent Care Claim will include an explanation of the expedited review process available for such claims.

Filing an Appeal

If you receive a notice of initial claim denial and you wish to challenge the denial, you must file an appeal with the Claims Administrator within 180 days of receipt of the notice of initial claim denial. Your appeal must be in writing and transmitted either by mail or a reasonably available electronic media. Your appeal must explain why you think your Claim should not have been denied and include any additional information, materials, or documentation supporting your Claim. You may also submit written comments, documents, records, and other information relating to your Claim. Upon request and free of charge, you will be provided with reasonable access to, and copies of, all documents, records and other information relevant to your Claim.

Review of Appeal

The persons reviewing your appeal will grant no deference to the original Claim denial but will assess the information you provide as if they were looking at the Claim for the first time. Also, the persons reviewing your appeal will not be the same persons who made the initial decision, nor will they be subordinates of those individuals. Upon request and free of charge, you will also be provided reasonable access to and copies of, all documents, records, and other information relevant to your Claim.

If the initial Claim denial is based on medical judgment (e.g., it was based on an assessment that your treatment was experimental or was not medically necessary), the Claims Administrator must consult with an expert in the appropriate field when reviewing the Claim. The expert will not be someone who was consulted in the initial review of your Claim or a subordinate of anyone consulted in that review. The identity of any expert consulted, whether or not his or her opinion is relied on in determining your Claim, will be retained as information relevant to your Claim.

Expedited Review for Urgent Care Claims

You may request an expedited review for an Urgent Care Claim. Your request may be made orally or in writing and all necessary information, including the Claims Administrator's determination on review, will be transmitted by telephone, facsimile, email, or other similarly expeditious methods.

Notice of Determination on Appeal

Timing of Notice of Determination on Appeal

Pre-Service Claim

If you appeal the initial denial of a Pre-Service Claim, the Claims Administrator will notify you of its determination on review (whether adverse or not) within a reasonable period of time considering the medical circumstances, but not later than 30 days after receipt of the appeal.

Urgent Care Claim

If you appeal the initial denial of an Urgent Care Claim, the Claims Administrator will notify you of its determination on review (whether adverse or not) as soon as possible taking into account the medical circumstances, but no later than 72 hours after receipt of the appeal.

Post-Service Claim

If you appeal the initial denial of a Post-Service Claim, the Claims Administrator will notify you of its determination on review (whether adverse or not) within a reasonable period of time, but not later than 60 days after receipt of the appeal.

If your Claim is for benefits conditioned upon a determination of disability, you will be notified of the determination on review (whether adverse or not) within a reasonable period of time, but not later than 45 days after receipt of the appeal.

Form and Content of Notice of Denial on Appeal

If your Claim is denied upon appeal, in whole or in part, the Claims Administrator will provide you with a written or electronic (e.g., by e-mail) explanatory notice of its determination in a culturally and linguistically appropriate manner. The notice of denial on appeal will:

provide information to help you identify the Claim including, upon request and when applicable, the diagnosis and treatment codes and the meanings of those codes;

inform you of the specific reasons for the denial and include any denial code and its corresponding meaning;

provide you with a description of the Plan's standard, if any, used in denying the Claim;

inform you of the specific

describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Form and Content of Notice of Initial Claim Denial

Any adverse benefit determination, including any denial, reduction, or termination, in whole or part, of the benefit for which you filed a Claim, or any rescission of coverage, is a Claim denial. This includes any determination based on eligibility.

If your initial Claim is denied in whole or in part, or if your coverage is rescinded or terminated for cause, the Claims Administrator will provide you with a written or electronic (e.g., by e-mail) explanatory notice of its determination. This notice of claim denial will:

inform you of the specific reasons for the denial of your initial Claim;

inform you of the pertinent Plan provisions on which the denial is based;

describe any additional materials necessary to perfect your Claim, and explain why this material is necessary; and

include an explanation of the Plan's appeal procedures, including information about how to initiate an appeal and the applicable time limits; and a statement that you have a right to bring a civil action in court if your Claim is denied after you have exhausted the required appeal procedures.

Filing an Appeal

If you receive a notice of initial claim denial and you wish to challenge the denial, you must file an appeal with the Claims Administrator within 60 days of receipt of the notice. Your appeal must be in writing and transmitted either by mail or a reasonably available electronic media. Your appeal must explain why you think your Claim should not have been denied and include any additional information, materials, or documentation supporting your Claim. You may also submit written comments, document

Form and Content of Notice of Denial on Appeal

If your Claim is denied upon appeal, in whole or in part, the Claims Administrator will provide you with a written or electronic (e.g., by e-mail) explanatory notice of its denial in a culturally and linguistically appropriate manner. This notice of denial on appeal will:

inform you of the specific reasons for the denial;

inform you of the specific Plan provisions on which the denial is based;

provide an explanation of additional levels of appeal that the Plan makes available, if any, including information about how to initiate an appeal and the applicable time limits;

contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the decision to deny your Claim (in whole or in part);

contain a statement that you have a right to bring a civil action in court if your Claim is denied after you have exhausted the required appeal procedures.

The decision of the Claims Administrator on appeal is final, subject to the order of a federal court in a civil action.

Filing Civil Action

If you have exhausted the required appeal procedures and your Claim is denied in whole or in part, you will have the right to file a civil action in court. If you do not exhaust the required appeal procedures, the claim you file in court will be subject to dismissal. Unless otherwise provided in an applicable Insurance Contract or Booklet, any civil action must be filed within one year of the date on which you receive the final notice of denial on appeal.

Failure of Claims Administrator to Follow Procedures

If the Claims Administrator fails to comply with any of the required deadlines or fails to inform you adequately of your procedural rights, you may treat a Benefit Program's claims procedures as having been completed and immediately file a civil action in court.

Unless otherwise provided in an applicable Insurance Contract or Booklet, any civil action must be filed within one year of the date you knew, or should have known, of the material failure to comply with these procedures.

Claims Under the Long-Term Disability Program and Claims Under Other Benefit Programs for Benefits Conditioned Upon the Claims Administrator's Determination of Disability

This section describes the procedures for filing and processing Claims under the Long-Term Disability Program. These rules also apply to Claims under other Benefit Programs if the Claim is for benefits that are conditioned upon the Claims Administrator's determination of disability.

Filing a Claim

To file a Claim for benefits under the Long-Term Disability Program, you must send a completed Claim form, and any materials or documentation required by the form, to the Claims

if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, explain the scientific or clinical judgment for the denial, or include a statement that an explanation will be provided free of charge upon request;

describe any additional materials necessary to perfect your Claim, and explain why this material is necessary;

include an explanation of the Plan's appeal procedures, including information about how to initiate an appeal and the applicable time limits; and a statement that you have a right to bring a civil action in court if your Claim is denied after you have exhausted the required appeal procedures;

include an explanation of the basis for disagreeing with, or not following: the views presented by you of health care professionals treating you or vocational professionals evaluating your Claim; the views of medical or vocational experts obtained by the plan even if the views were not relied upon in making the decision to deny your Claim; a disability determination made by the Social Security Administration;

describe any rule, standard, guideline, protocol, or similar document or criteria relied on in making the initial determination; or include a statement that one does not exist; and

include a statement that you are entitled to receive, free of charge and on request, reasonable access to, and copies of, all document, records, and other information relevant to your Claim.

Filing an Appeal

If you receive a notice of initial claim denial and you wish to challenge the denial, you must file an appeal with the Claims Administrator within 180 days of receipt of the notice of initial claim denial. Your appeal must be in writing and transmitted either by mail or a reasonably available electronic media. Your appeal must explain why you think your Claim should not have been denied and include any additional information, materials, or documentation supporting your Claim. You may also submit written comments, documents, records, and other information relating to your Claim. Upon request and free of charge, you will be provided with reasonable

Notice of Determination on Appeal

Timing of Notice of Determination on Appeal

If you appeal the initial denial of your Claim, the Claims Administrator will notify you of its determination on review (whether adverse or not) within a reasonable period of time, but not later than 45 days after receipt of the appeal. An extension of up to 45 days is permitted if the Claims Administrator decides that special circumstances require the extension. You will receive written notice of the extension before the end of the initial determination period, including an explanation of the circumstances requiring the extension and the date by which the Claims Administrator expects to make its decision. If an extension is required because there is information missing from your Claim, the notice will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Form and Content of Notice of Denial on Appeal

If your Claim is denied upon appeal, in whole or in part, the Claims Administrator will provide you with a written or electronic (e.g., by e-mail) explanatory notice of its denial in a culturally and linguistically appropriate manner. The notice of denial on appeal will:

inform you of the specific reasons for the denial;

provide you with a description of the Plan's standard, if any, used in denying the Claim;

inform you of the specific Plan provisions on which the denial is based;

provide an explanation of additional levels of appeal that the Plan makes available, if any, including information about how to initiate an appeal and the applicable time limits;

contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the decision to deny your Claim (in whole or in part);

contain a statement that you have a right to bring a civil action in court if your Claim is denied after you have exhausted the required appeal procedures and a description of any time limitations that apply to that right, including the calendar date on which the limitations expire;

if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, explain the scientific or clinical judgement for the denial, or include a statement that an explanation will be provided free of charge upon request;

an explanation of the basis for disagreeing with, or not following: the views presented by you of health care professionals treating you or vocational professionals evaluating your Claim; the views of medical or vocational experts obtained by the plan even if the views were not relied upon in making the decision to deny your Claim; a disability determination made by the Social Security Administration; and a description of any rule, standard, guideline, protocol, or similar document or criteria relied on in making the initial determination; or a statement that one does not exist.

Before the Claims Administrator makes its decision, the Plan will notify you of any additional grounds for denying your Claim and provide you with an opportunity to present additional evidence in response. This evidence will be provided as soon as possible and sufficiently in advance of the date the Plan must provide notice of its decision on appeal.

The decision of the Claims Administrator on appeal is final, subject to the order of a federal court in a civil action.

Filing Civil Action

If you have exhausted the required appeal procedures and your Claim is denied in whole or in part, you will have the right to file a civil action in court. If you do not exhaust the required appeal procedures, the claim you file in court will be subject to dismissal. Unless otherwise provided in an applicable Insurance Contract or Booklet, any civil action must be filed within one year of the date on which you receive the final notice of denial on appeal.

Failure of Claims Administrator to Follow Procedures

If the Claims Administrator fails to comply with any of the required deadlines or fails to inform you adequately of your procedural rights, you may treat a Benefit Program's claims procedures as having been completed and immediately file a civil action in court.

Unless otherwise provided in an applicable Insurance Contract or Booklet, any civil action must be filed within one year of the date you knew, or should have known, of the material failure to comply with these procedures.

Claims Under Dependent Care FSA Program

Filing a Claim

Claims for reimbursement of Eligible Dependent Care Expenses under the Dependent Care FSA Program must be submitted on Claim forms available from the Claims Administrator. All Claims must:

Be for a paid expense incurred during the Plan Year; and

Include:

Amount, date, and nature of the expense;

Name, address, and the federal taxpayer identification number or employer identification number of the person, organization, or entity to which the expense was or is to be paid;

Name of the person for whom the expense was incurred, and the relationship of that person to you;

Amount recovered or recoverable from any other source with respect to the expense;

Written evidence from an independent third party stating that the expense has been incurred, the amount of the expense (e.g., bills, invoices, receipts, or other writings showing the amount of the expense); and

Any other information deemed necessary by the Claims Administrator in order to make a reasonable determination that the expense is reimbursable.

Generally, to obtain reimbursement of Eligible Dependent Care Expenses incurred during a Plan Year, you must submit a Claim to the Claims Administrator within 91 days after the end of the Plan Year. However, if your participation in the Dependent Care FSA Program ends before the end of the Plan Year (e.g., because your employment terminates), final Claims for Eligible Dependent Care Expenses incurred prior to the date your participation ends must be submitted within 91 days of the date your participation ends.

Small claims may be held until they reach a reasonable threshold amount to be established by the Claims Administrator.

Notice of Initial Claim Denial

If your Claim is denied, the Claims Administrator will notify you within a reasonable period of time, but not later than 30 days after receipt of the Claim, or 45 days if the Claims Administrator determines an extension is necessary due to matters beyond the control of the Plan and notifies you within the original 30-day period of the reason for the extension and date by which the determination is intended to be made. If the extension is necessary because you failed to submit a complete Claim, the notice will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Filing an Appeal

If you receive a notice of initial claim denial and you wish to challenge the denial, you must file an appeal with the Claims Administrator within 60 days of receipt of the notice. Your appeal must be in writing and transmitted either by mail or a reasonably available electronic media. Your appeal must explain why you think your Claim should not have been denied and include any additional information, materials, or documentation supporting your Claim. You may also submit written comments, documents, records, anr2l3-1.207t4l9ei7005 Tct(nta)-4. explanation of the circumstances requiring the extension and the date by which the Claims Administrator expects to make its decision. If an extension is required because there is information missing from your Claim, the noti ce will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Claims Based Solely on Eligibility to Participate in Plan or Benefit Program and Claims of ERISA or Code Violations

special circumstances require the extension. You will receive written notice of the extension before the end of the initial determination period, including an explanation of the circumstances requiring the extension and the date by which the Claims Administrator expects to make its decision. If an extension is required because there is information missing from your Claim, the notice will describe the missing information and you will be given at least 45 days from receipt of the notice to provide that information before the Claims Administrator makes its determination.

Filing Civil Action

If you have exhausted the required appeal procedures and your Claim is denied in whole or in part, you will have the right to file a civil action in court. If you do not exhaust the required appeal procedures, the claim you file in court

Expenses for benefits that are provided, or

Third: For a patient who is a dependent Child, unless there is a court order or judgment stating otherwise, the plan responsible for payment is determined as follows:

If the dependent Child's <u>parents are married or living together</u>, whether or not they have ever been married, the group health plan of the parent whose birthday occurs earlier in the calendar year will pay. If both parents have the same birthday, the plan that has covered the parent the longest will pay.

If the dependent Child's parents are divorced, legally separated, or not living

pay, offset any recovery, or in any way be responsible for any fee or costs associated with pursuing a claim unless the Plan agrees to do so in writing.

You and your Covered Dependents must cooperate fully with the Plan Administrator to protect the Plan's right of reduction, recovery, reimbursement or subrogation and must sign any reimbursement or subrogation agreement or other document that may be requested by the Plan Administrator, although the plan may exercise its rights under this section whether or not any such agreement is requested or signed by you. You and your Covered Dependents are responsible for notifying the plan in writing of any claim you may have against another party who may be responsible for benefits paid under this Plan. Your notice must be provided within 30 days of the date that any notice is given to any party, including an attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to any injury, illness, or condition for which the Plan has paid benefits.

If you, your agent, a trust, or any other person or entity receive any proceeds of settlement or judgment on behalf of you or your Covered Dependent, and if the plan has a right to any portion of those proceeds, you, your agent, or the third party must hold those proceeds in trust for the plan. The plan may recover any expenses it incurs because you or your Covered Dependents failed to cooperate in enforcing the plan's rights under this section. If you or your Covered Dependents do not comply with this section, your right to benefits under the plan may be forfeited.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Recociliation Act of 1985, as amended ("COBRA") provides Qualified Beneficiaries, upon the occurrence of a Qualifying Event, the right to continuation coverage under the Medical/Rx, Dental, Vision, EAP and Health Care FSA Programs beyond the time the coverage would normally end ("COBRA Continuation Coverage

Notice of Qualifying Event Required

The Plan offers COBRA Continuation Coverage to Qualified Beneficiaries only after the COBRA Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the reduction of your hours or end of your employment, your death, or your becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the Qualifying Event.

For the other Qualifying Events (e.g., your divorce or legal separation, or your Child's losing eligibility for coverage as a dependent Child), you must notify the COBRA Administrator within 60 days after the Qualifying Event occurs. You must provide written notice of the Qualifying Event ot the COBRA Administrator. Emailed notices or notices sent by facsimile will be considered written notices. Oral or voice-mailed notices will not be accepted.

Your notice must include: the name and contact information of the person giving notice, the name and address of the employee or former employee who is or was a Plan Participant, a description of the Qua lifying Event, the date of the Qualifying Event, any documents or materials relevant to the Qualifying Event (e.g., a copy of a judgment of divorce in the event of a divorce), and the names, addresses, and Social Security numbers of the Covered Dependents affected by the Qualifying Event. Failure to notify the COBRA Administrator in a timely manner will mean that neither you nor your Covered Dependents will be able to elect COBRA Continuation Coverage for these Qualifying Events.

Electing COBRA Continuation Coverage

Once the COBRA Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. To elect Continuation Coverage, you must complete the election form and send it in according to the directions on the form. Each Qualified Beneficiary has a separate right to elect COBRA Continuation Coverage. For example, your Spouse may elect coverage even if you do not. COBRA Continuation Coverage may be elected fo only one, several, or for all dependent Children who are Qualified Beneficiaries. A parent may elect or reject Continuation Coverage for any minor Children. You and your Spouse may elect Continuation Coverage for each other, but cannot reject coverage for the other person. After you have submitted your election forms, if it is determined that you or a Covered Dependent is not entitled to Continuation Coverage, you will be provided with a written explanation of why the election of Continuation Coverage could not be honored.

In considering whether to elect COBRA Continuation Coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for whic h you are otherwise eligible, such as a plan sponsored by your Spouse's employer, within 30 days after your group health plan coverage ends because of the Qualifying Events listed above. You will also have the same special enrollment right at the end of COBJ 11.1w [(en*e)5(fu wil7.8(h)-.an)-4.8()-5.5(for)-5.4(w)-6(h Con)-5.66e-5.4

Cost of COBRA Continuation Coverage

Generally, each Qualified Beneficiary must pay the entire cost of COBRA Continuation Coverage. The cost cannot exceed 102% (or in the case of an extension due to a disability, 150%) of the cost to the Plan for coverage of a similarly-situated Plan Participant and/or beneficiary who is not receiving COBRA Continuation Coverage. The cost for a similarly-situated Plan Participant or beneficiary includes both the Employer contributions and Employee Contributions for coverage. The required payment for each COBRA Continuation period for each option will be described in the notice sent to you.

Paying for COBRA Continuation Coverage

First Payment for COBRA Continuation Coverage

If you elect COBRA Continuation Coverage, you do not have to send any payment with the election form. You must, however, make your first payment no later than 45 days after the date of your election. (This is the date the election notice is post-marked, if mailed.) If you miss this first payment date, you will lose all COBRA Continuation Coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your payment.

Periodic Payments for COBRA Continuation Coverage

After your first payment for COBRA Continuation Coverage, you will be required to make monthly payments for each subsequent coverage period. Each monthly payment for COBRA Continuation Coverage is due on the dates stated in the COBRA election forms sent to you. If you make a monthly payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan is not legally obligated to send periodic notices of payments due for these coverage periods.

Grace Periods for Monthly Payments

Although monthly payments are due on the dates stated in the COBRA election forms, you will be given a grace period of 30 days after the first day of each coverage period to make each periodic payment. Your COBRA Continuation Coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make a monthly payment before the end of the grace period for that coverage period, you will lose all rights to COBRA Continuation Coverage under the Plan retroactive to the date payment was due. If a partial premium payment is made that falls short of the current amount due by a minimal amount, you will be notified, and either the amount

29 months when the Qualifying Event is your end of employment or reduction of your work hours and you or a Covered Dependent qualify for a disability extension (refer to "Disability" below) during the 18-month COBRA Continuation Coverage period;

for your Covered Dependents for 36 months when the Qualifying Event is your divorce or legal separation, your death, your enrollment in Medicare (Part A or Part B) or a Child's loss of Eligible Dependent status; or

for your Covered Dependents, when the Qualifying Event is your end of employment or reduction in your work hours, and you enrolled in Medicare fewer than 18 months before the Qualifying Event, for 36 months after the date you enrolled in Medicare. For example, if you enrolled in Medicare eight months before you terminated employment, Continuation Coverage for your Covered Dependents could last up to 36 months from the date you enrolled in Medicare, which is 28 months after the date of the Qualifying Event.

COBRA Continuation Coverage will be terminated before the end of the maximum period if:

any required premium payment is not paid in full on time; or

after electing COBRA Continuation Coverage, a Qualified Beneficiary:

becomes covered under another employer's group health plan; or becomes enrolled in Medicare benefits, under Part A or Part B, or both; or

the Employer ceases to provide any group health plan for its employees.

COBRA Continuation Coverage also may be terminated for any reason the Plan would terminate coverage of a Participant or beneficiary not receiving COBRA Continuation Coverage, such as fraud. If your period of COBRA Continuation Coverage is terminated for any reason before the end of your maximum period, you will be notified of the termination and provided with an explanation of why it was terminated.

At the end of the 18-month or 36-month COBRA Continuation Coverage period, you must be allowed to enroll for individual conversion coverage, but only if this opportunity is provided under the specific Benefit Program for which you elected COBRA Continuation Coverage.

Extending Length of COBRA Continuation Coverage

There are two ways in which a COBRA Continuation Coverage period of less than 36 months may be extended: if a Qualified Beneficiary is disabled or a second Qualifying Event occurs. You must notify the COBRA Administrator in writing of a disability or second Qualifying Event in order to extend the period of COBRA Continuation Coverage. Your failure to provide notice of a disability or second Qualifying Event may affect the right to extend the period of COBRA Continuation Coverage.

<u>Disability</u>

If you or any Covered Dependent is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, you and your entire family

may be entitled to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability has to have started at some time before the 60th day of COBRA Continuation Coverage and stat least until the end of the 18-month period of COBRA Continuation Coverage.

You or a Covered Dependent must notify the COBRA Administrator in writing on or before the 60th day after the latest of: (a) the date of th

Military Leave Continuation Coverage

If you are called to active duty in the United States Armed Forces, the Coast Guard, the National Guard or the Public Health Service, you will be offered, under the Uniformed Services Employment and Reemployment Act of 1994, as amended ("

Past, present, or future payment for the provision of health care to an individual;

that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual.

Uses and Disclosures of PHI by Plan

The Plan may disclose PHI to the Employer only if the Privacy Rules specifically permit the use or disclosure, or if the individual authorizes the Plan to use or disclose PHI to the Employer.

Plan Administrative Functions

Once the Employer receives PHI from the Plan, it may use or disclose PHI only for Plan Administration Functions. "Plan Administration Functions" are administrative tasks performed by the Employer on behalf of the Plan and exclude employment-related functions and functions performed by the Employer in connection with any other benefit or benefit plan of the Employer. Plan Administration Functions include, but are not limited to:

Enrollment and disenrollment activities;

Verification of participation in the Plan;

Obtaining premium contributions;

Determining eligibility for benefits;

Activities to coordinate benefits with other plans and coverages;

Final adjudication of appeals of claim denials;

Exercise of the Plan's rights of reimbursement and subrogation;

Assisting Participants in eligibility, benefit claims matters, inquiries, and appeals;

Obtaining premium bids;

Evaluation of health plan design;

Activities relating to placement, renewal, or replacement of a contract of health insurance or health benefits (including stop-loss and excess loss insurance);

Legal services and auditing functions (including fraud and abuse detection);

Business planning, management and general administration;

Making claims under stop-loss or excess loss insurance; and

Activities in connection with the transfer, merger or consolidation of the Plan, including due diligence.

Privacy Obligations of Employer With respect to PHI created by or received from the Plan, the Employer will:

not use or further disclose the PHI other than

Electronic Data Security Obligations of Employer

To the extent the Employer maintains electronic PHI, the Employer will:

reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Employer on behalf of the Plan as required by the HIPAA Security Rules;

implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the Plan;

ensure that the required separation between the Plan and the Employer is supported by reasonable and appropriate security measures;

ensure that any agents, including subcontractors, to whom it provides electronic PHI agree to implement reasonable and appropriate security measures to protect the electronic PHI; and

report to the Plan any security incident involving PHI of which it becomes aware.

Qualified Medical Child Support Orders

The Plan Administrator will honor an order that is a "qualified medical child support order" within the meaning of ERISA Section 609(a)(2)(A) ("**QMCSO**

procedures. Within a reasonable period of time after receipt of the order, the Plan Administrator will determine whether the order or NMSN is a QMCSD and notify the Participant and Alternate Recipient of its determination. If the order is an appropriately completed NMSN and it is deemed to be a QMCSO, the Plan Administrator will also, within 40 business days of receipt of the NMSN, notify the issuing court or agency and the custodial parent whether coverage is available to the child under the terms of the Plan and, if so, the steps to be taken to effectuate coverage.

If the Plan Administrator determines that an order or NMSN is not a QMCSO, the notice will include an explanation of the defective or missing provisions.

The Participant and each Alternate Recipient have the right to request in writing, within 30 days after being notified of the Plan Administrator's determination, that the Plan Administrator reconsider its determination of the order or NMSN. The Participant and each Alternate Recipient may present additional materials to the Plan Administrator for review. The Plan Administrator will provide sufficient information for the Participant and/or Alternate Recipient to understand available options and to assist in appropriately completing the order or NMSN. If the Plan Administrator requests additional information or material, you will be given a reasonable period of td35.5(masssubder)-5.4(or)-6(A5.5ga)-5Tj T*DAlter0005 Tc .a.[(reason-5.6(ben will p

or beneficiary or in determining or making any payment of benefits to that individual. The Plan will pay benefits in accordance with any assignment of rights made by or on behalf of that individual as required under a State Medicaid Plan pursuant to Section 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to the individual under a State Medicaid Plan and this Plan has a legal liability to make payments for the same items or services, payment under the Plan will be made in accordance with any state law that provides that the State has acquired the rights with respect to the individual to payment for those items and services under this Plan.

Maternity Benefits

Pursuant to federal law, the Plan, or any insurance issuer providing coverage for maternity benefits under the Plan, will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law does not prohibit the mother's or newborn's treating physician, after consultation with the mother, from discharging the mother or her newborn Child earlier than 48 hours (or 96 hours, as the case may be). The Plan will not require a medical provider to obtain authorization from the Plan (or the insurance issuer) for prescribing a length of stay not in excess of the above periods. Nothing in this provision, however, requires that a woman covered under this Plan give birth in a hospital or stay in the hospital a fixed period of time following the birth of her Child.

Post-Mastectomy Benefits

To the extent the Plan (or any insurance issuer) provides benefits for mastectomies, it will also provide coverage for reconstructive surgery of either or both breasts following a mastectomy (including for the purpose of attaining a symmetrical appearance) and for the treatment of physical complications at all stages of the mastectomy and the recovery period, including lymphedemas.

Genetic Information Nondiscrimination Act

The Plan complies with the Genetic Information Nondiscrimination Act of 2008. Participants and Eligible Dependents are not required to undergo genetic testing, nor shall the Plan use genetic information related to any employee or family me mber to determine eligibility to participate in the plan or to determine any required Employee Contribution for any health benefit provided under the plan.

Mental Health Parity and Addiction Equity Act

The Plan will comply with the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") to the extent MHPAEA is applicable to the Plan. Nothing in the Plan will be construed to require any Benefit Program to

Indemnification

The Employer will indemnify each employee to whom it has delegated responsibilities for the operation and administration of the Plan against any and all claims, losses, damages, expenses, and liabilities arising from any action or failure to act, except when it is judicially determined to be due to the gross negligence or willful misconduct of the employee. The Employer may choose, at its own expense, to purchase and keep in effect sufficient lia bility insurance to cover any claim, loss, damage, expense, or liability arising from any employee's action or failure to act.

Type of Plan The Plan is a welfare benefit pl

Construction

Words used in the masculine apply to the feminine where applicable. Wherever the context of the Plan dictates, the plural shall be read as the singular, and the singular as the plural.

Non-Assignability of Rights

No interest under the Plan is subject to assignment or alienation, whether voluntary or involuntary. Any attempt to assign or alienate any interest will be void. Direct payment of a benefit to a provider on your behalf shall not be considered an assignment of the benefit.

Errors

Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.

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EXECUTION

IN WITNESS WHEREOF, Hope College has caused this amendment and restatement of the Plan to be executed by its duly authorized employee thisWKday of 'HFHPEHU, 2020.

HOPE COLLEGE 117 2 1AA HINKINAA By: 1 %HQHILWV0DQDJHU Its:

APPENDIX A

PLAN DOCUMENTS CHART Effective July 1, 2020

Benefit Program	Insurance Policy/Contract	Booklets
Donont i rogram	-	Doordots
	(if applicable)	

APPENDIX B

BENEFIT PROGRAM INFORMATION CHART Effective July 1, 2020

Benefit Program	Funding and Claim Type	Insurance Company or Claims Administrator Contact Information
Medical/Rx Program	Self-Funded	Medical: Blue Cross Blue Shield of Michigan 86 Monroe Center, N.W. Grand Rapids, MI 49503 (888) 890-5712 www.bcbsm.com Prescription drug: CVS/Caremark (888) 321-4206 www.caremark.com For Paper Claims: P.O. Box 52136 Phoenix, AZ 85072 For Mail Service Claims: P.O.Bos 659541 San Antonio, TX 78265
Dental Program	Insured	Blue Cross Blue Shield of Michigan

Benefit Program	Funding and Claim Type	Insurance Company or Claims Administrator Contact Information
Long-Term Disability Program	Insured	The Lincoln National Life Insurance Company 8801 Indian Hills Drive Omaha, NE 68114-4066 (800) 423-2765 www.lincolnfinancial.com
Life /AD&D Insurance Program	Insured	The Lincoln National Life Insurance Company 8801 Indian Hills Drive Omaha, NE 68114-4066 (800) 423-2765 www.lincolnfinancial.com
Group Travel Accident	Insured	ACE American Insurance Company Chubb NA Accident & health P.O. Box 5124 Scranton, PA 18505-0556 (800) 366-0627 (inside the US) (302) 476-6794 (outside the US)
EAP	Self-Insured	Ulliance, Inc. 900 Tower Drive #600 Troy, MI 48098 (248) 680-4611
Pre-Tax Payment Program	N/A	Plan Administrator
Dependent Care FSA Program	N/A	PNC Benefit Plus P.O. Box 2865 Fargo, ND 58108 (844) 356-9993 www.participant.pncbenefitplus.com

Benefit Program	Funding and Claim Type	Insurance Company or Claims Administrator Contact Information
Health Care FSA	Self-Insured	PNC Benefit Plus P.O. Box 2865
Program	<u>Filing a Claim</u> :	Fargo, ND 58108 (844) 356-9993 www.participant.pncbenefitplus.com
HSA Contributions Program	N/A	PNC Benefit Plus P.O. Box 2865
riogram	Employer-designated HSA	Fargo, ND 58108
	<u>Custodian</u> :	(844) 356-9993
		www.participant.pncbenefitplus.com
COBRA Administrator	N/A	Plan Administrator