THE UNIVERSITY OF PENNSYLVANIA
HEALTH AND WELFARE PROGRAM
(As Amended and Restated Effective July 1, 2021)
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THE UNIVERSITY OF PENNSYLVANIA
HEALTH AND WELFARE PROGRAM

(As Amended and Restated Effective July 1, 2021)

The Trustees of the University of Pennsylvania (the "University") previously established the University of Pennsylvania Health and Welfare Program (the "Program") to provide health and welfare benefits to its eligible employees and their eligible dependents. The health and welfare benefits provided to Program participants may be provided through arrangements that are funded or unfunded, insured or uninsured, or a combination thereof, and may provide varying benefits to different groups of participants. The various health and welfare benefit programs (each a "Plan", or, collectively, the "Plans") made available to participants under the Program are identified in Appendix A as may be amended by the University from time to time. The benefits provided under the Plans are described in the applicable Contract (as defined below), which are hereby incorporated into the Program.

The Program is intended to qualify as an "accident and health" plan within the meaning of section 105(c) of the Internal Revenue Code of 1986, as amended (the "Code") and satisfy the requirements of Code section 125 so as to constitute a "cafeteria plan" and to otherwise comply with the applicable requirements of the Code and, when applicable to a particular Plan as indicated in Appendix A, the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

The University originally adopted the Program effective as of July 1, 2000 and the Plan has been amended from time to time since its original adoption. The University now again amends and restates the Program, effective January 1, 2020, to incorporate previously adopted amendment, to incorporate changes required by applicable law and to make certain other clarifying changes and updates to the Program.

ARTICLE I
DEFINITIONS

As used herein, the following terms shall have the following meanings unless the context clearly indicates otherwise.

Section 1.1 "Accounts" shall mean the various accounts maintained under the Program for each Participant to which shall be credited the Contributions made by or on behalf of such Participant. A Participant's Accounts may include the following:

(a) his or her Salary Reduction Account to which shall be allocated his or her Section 125 Contributions made pursuant to Section 4.1(a) and 4.1(b)(1) to provide benefits under the Medical Plan, Dental Plan, Vision Plan and Group Life Insurance Plan, as elected by the Participant;
(b) his or her Health Care Expense Account to which shall be allocated the amount of his or her Contributions which he or she has designated to provide benefits under the Health Care Pre-Tax Expense Account Plan; and

(c) his or her Dependent Care Expense Account to which shall be allocated the amount of his or her Contributions which he or she has designated to provide benefits under the Dependent Care Pre-Tax Expense Account Plan.

(d) his or her After-Tax Contributions Account to which shall be allocated his or her After-Tax Contributions made pursuant to Section 4.1(b)(2) to provide benefits under the Group Life Insurance Plan, the Dependent Life Insurance Plan and the Long-Term Care Plan, as elected by the Participant, and made pursuant to Section 3.7 to purchase COBRA Continuation Coverage under Article III;

Section 1.2 "Affiliate" means any entity (other than the University) that is a member of a controlled group (within the meaning of section 414(b) of the Code) of which the University is a member; any member of an affiliated service group, as determined under section 414(m) of the Code, of which the University is a member; any trade or business that is under common control with the University, as determined under section 414(c) of the Code; and any other entity which is required to be aggregated with the University under section 414(o) of the Code. An entity shall be considered an Affiliate only with respect to such period as the relationship described in the preceding sentence exists. "50% Affiliate" means an Affiliate, but determined with "more than 50%" substituted for the phrase "at least 80%" in section 1563(a) of the Code, when applying sections 414(b) and 414(c) of the Code. For purposes of section 414(b) of the Code, a controlled group shall be present where at least 80% of an entity's directors, trustees or individual members of the governing body are either representative of, or are directly or indirectly controlled by, or directly or indirectly control, another entity. A controlled group is also present where an entity directly or indirectly receives at least 80% of its operating funds from another entity, and there is a degree of common management or supervision between the two entities.

Section 1.3 "After-Tax Contributions" shall mean those amounts paid into a Participant's After-Tax Contributions Account which are deducted from compensation or otherwise contributed on an after-tax basis to be used to purchase Dependent Life Insurance or Group Life Insurance or to purchase COBRA Continuation Coverage.

Section 1.4 "Claims Administrator" shall mean one or more persons, committees, or Insurers designated by the Plan Administrator or in accordance with the terms of a Contract to administer claims under the Program. In the absence of such designation, the Plan Administrator shall be the Claims Administrator.

Section 1.5 "Code" shall mean the Internal Revenue Code of 1986, as amended from time to time, and any successor statute of similar purpose.

Section 1.6 "Compensation" shall mean, for purposes of making After-Tax Contributions and Section 125 Contributions, a Participant's compensation as determined by the Employer.
Section 1.7   "Contract" shall mean any of the insurance contracts, including a minimum premium or administrative services only contract, or health care provider agreements issued by an Insurer to provide benefits under the Plans. The term Contract shall also include any schedule or description of benefits that is utilized by a provider of administrative services to facilitate the provision of benefits under the Plans or the provision of services under the Plans, including, but not limited to, claims administration services.

Section 1.8   "Contributions" shall mean the various types of contributions made by or on behalf of each Participant, including Flex Dollar Credit Contributions and Section 125 Contributions.

Section 1.9   "Dependent" shall mean:

(a) For purposes of the Medical Plan, Dental Plan and Vision Plan:

   (1) the Participant's Spouse (including a Spouse of a common law marriage);

   (2) the Participant's or his or her Spouse's child:

      (i) up to the last day of the month in which your child reaches age 26 unless a Contract has an older limiting age, and

      (ii) beyond age 26 if the child is incapable of self-support because of a mental or physical condition that existed prior to age 26, and who was eligible for coverage as a Dependent prior to age 26;

   (3) notwithstanding the foregoing, dependents in full-time military service are not eligible for coverage under certain options.

(b) For purposes of the Dependent Life Insurance Plan, an Eligible Employee's Spouse and any unmarried child who is at least 30 days old but less than 26 years of age.

(c) For purposes of the Health Care Pre-Tax Expense Account Plan and Dependent Care Pre-Tax Expense Account Plan, as in the definitions set forth in the applicable Appendices for such Plans.

The determination of whether a dependent child has ceased to be eligible for coverage as a Dependent by virtue of age shall be made in accordance with the applicable Contract.

The Plan Administrator may require such proof of a child's disability or his or her status as a full-time student as it may, in its sole discretion, determine from time to time. In addition, the enrollment of a common law Spouse shall require the completion of such certification forms as may be required by the Plan Administrator.
The term "child" shall include a natural child, stepchild, adopted child or child placed with the Employee for adoption. Under the terms of certain Contracts, "child" may include a child for whom a Participant is the legal guardian.

If both parents of a child are Participants under the Program, a child may only be a Dependent of one such Participant for purposes of the Medical Plan, Dental Plan, Vision Plan and Dependent Life Insurance Plan.

Section 1.10 "Effective Date" shall mean July 1, 2021, the effective date of this amendment and restatement of the Program.

Section 1.11 "Election Period" shall mean the period specified by the Plan Administrator during each annual open enrollment or at any other time during the Plan Year during which an Eligible Employee may prospectively select benefits hereunder. In general, for newly Eligible Employees hired (or with an eligibility date) from the first to the fifteenth of the month, the Election Period shall be a period of at least 30 days beginning on the first of the following month. For newly Eligible Employees hired (or with an eligibility date) from the sixteenth to the end of the month, the Election Period shall be a period of at least 30 days beginning with the second first of the month following hire or change in status.

Section 1.12 "Eligible Employee" shall mean:

(a) An Employee who is a Full-Time member of the Employer's staff or faculty (in a benefits-eligible faculty position) and a limited service member of the Employer's staff and is either: (1) a United States citizen, or (2) a foreign national paid in United States dollars. To be an Eligible Employee, a limited service staff member must work at least 35 hours per week for nine or more months of the year.

(b) An Employee who is a part-time member of the Employer's staff or faculty in a benefits eligible job title in accordance with the personnel policies and practices of the Employer, except as follows:

(1) No Flex Dollar Credit shall be provided under Section 4.1(a).

(2) Part-time Employees shall not be eligible for certain Options under the Group Life Insurance Plan as specified in the Contract, the Dependent Life Insurance Plan, the Long-Term Disability Plan, the Health Care Pre-Tax Expense Account Plan or the Dependent Care Pre-Tax Expense Account Plan.

(3) Contributions under the Group Life Insurance Plan must be made with After-Tax Contributions.

(c) A full-time visiting faculty, except as follows:

(1) No Flex Dollar Credit shall be provided under Section 4.1(a).
(2) The visiting faculty shall not be eligible for the Dental Plan, the Dependent Life Insurance Plan, the Health Care Pre-Tax Expense Account Plan or the Dependent Care Pre-Tax Expense Account Plan.

(3) Group-term life insurance shall be provided at no cost to the visiting faculty.

(d) "Eligible Employee" shall not include any individual included in a unit of employees covered by a collective bargaining agreement unless otherwise provided pursuant to the agreement between the Employer and such individual's collective bargaining representative, or any individual who performs services for the Employer as a leased employee within the meaning of section 414(n) of the Code. "Eligible Employee" shall not include any individual classified by the Employer as a contract worker or independent contractor who is not on the Employer's W-2 payroll. An individual who is not classified as a common law employee by the Employer shall not be considered an "Eligible Employee" for the purposes of the Plan no matter how classified by the Internal Revenue Service, other governmental agency or a court. Any change of classification of an individual shall, unless determined otherwise by the Employer, take effect on the actual date of such change without regard to any retroactive reclassification. If such an individual otherwise satisfies the requirements of this definition and is subsequently reclassified by the Employer, the Internal Revenue Service or a court as an Employee, such person, for purposes of this Plan, shall be deemed an Eligible Employee from the later of the actual or the effective date of such reclassification.

(e) Notwithstanding the foregoing, the Employer may, in its discretion, permit participation in the Plan by other full-time employees, part-time employees, former employees, or union employees, in accordance with the personnel policies and practices of the Employer.

Section 1.13 "Employee" shall mean an individual who is employed by the Employer (excluding employees of the Hospital of the University of Pennsylvania) or who performs services for the Employer as a leased employee within the meaning of section 414(n) of the Code. An individual shall cease to be an Employee in accordance with the personnel policies and practices of the Employer.

Section 1.14 "Employer" shall mean the University and/or any Participating Employer either collectively or individually as the context requires.

Section 1.15 "Employment Commencement Date" shall mean, for staff members, the date on which an Employee first performs an hour of service for the Employer, and for faculty members, the date on which the individual is appointed as a faculty member.

Section 1.16 "ERISA" shall mean the Employee Retirement Income Security Act of 1974, as it may from time to time be amended.

Section 1.17 "FMLA" shall mean the Family and Medical Leave Act of 1993.
Section 1.18  "Flex Dollar Credit" shall mean the amount determined under the collective bargaining agreement and accrued by the Employer for each Participant who is covered by a collective bargaining agreement that provides for such credits.

Section 1.19  "Full-Time" shall mean a normal work schedule of 35 or more hours a week for twelve months of the year. For faculty members, the Employee must be classified as full-time in accordance with the written personnel policies and practices of the Participating Employer.

Section 1.20  "Insurer" shall mean any insurance company, health care provider (including a health maintenance organization) or third-party administrator with which the Plan Administrator enters into a Contract to provide benefits to Participants or to provide administrative services with respect to the Program.

Section 1.21  "Participant" shall mean any Eligible Employee who meets the participation requirements of Article II.

Section 1.22  "Participating Employer" shall mean any Affiliate that is designated by the Plan Administrator as a Participating Employer under the Program. The University may require an adopting Participating Employer to execute a supplemental agreement evidencing its participation hereunder. A Participating Employer may revoke its acceptance of such designation at any time, but until such acceptance has been revoked, all of the provisions of the Program and amendments thereto shall apply to the Employees of the Participating Employer. In the event the designation as a Participating Employer is revoked, the Program shall be deemed terminated only as to such Participating Employer.

Section 1.23  "Plan Administrator" shall mean the Vice President for Human Resources or such other person or committee as may be appointed from time to time by the Executive Vice President of the University to supervise the administration of the Program.

Section 1.24  "Plan" or "Plans" shall mean any of the welfare benefit plans described in the Appendices attached hereto which shall include:

(a) the Medical Plan, described in Appendix A;
(b) the Dental Plan, described in Appendix B;
(c) the Group Life Insurance Plan, described in Appendix C;
(d) the Dependent Life Insurance Plan, described in Appendix D;
(e) the Health Care Pre-Tax Expense Account Plan, described in Appendix E;
(f) the Dependent Care Pre-Tax Expense Account Plan, described in Appendix F;
(g) the Vision Plan, described in Appendix G;
(h) the Long-Term Disability Plan, described in Appendix H; and
(i) the Long Term Care Plan, described in Appendix I.

Section 1.25 "Plan Year" shall mean the period of 12 months beginning on each July 1 and ending the following June 30.

Section 1.26 "Program" shall mean the University of Pennsylvania Health and Welfare Program.

Section 1.27 "Reelection Period" shall mean the period designated by the Plan Administrator for electing benefits for a succeeding Plan Year. In no event shall such Reelection Period extend beyond the last day of the Plan Year preceding the Plan Year for which the election is to become effective.

Section 1.28 "Reemployment Commencement Date" shall mean the first day on which an Employee completes an hour of service after previously terminating service with the Employer or, for faculty members, the date on which the individual is appointed as a faculty member.

Section 1.29 "Section 125 Contributions" shall mean the amount paid by the Employer pursuant to section 4.1(b)(i), through salary reduction, on behalf of a Participant to provide benefits in accordance with section 125 of the Code, which is allocable by the Participant to his or her Accounts under the Program.

Section 1.30 "Spouse" shall mean the lawfully recognized spouse of a Participant under the laws of the state in which the Participant resides. The Plan Administrator may require such proof of spousal status as it may, in its sole discretion, determine from time to time. No common law marriage that was entered into in Pennsylvania on or after September 17, 2003, shall be recognized. In addition, the term "Spouse" shall include a Participant's same-sex domestic partner if he or she is an individual who (1) prior to July 1, 2016, was participating with the Participant in a same-sex domestic partnership that was registered with the University’s Benefits Office and (2) was enrolled for coverage in the Plan as of July 1, 2016 and has been continuously covered since that time. Excepted at otherwise noted, all references to "spouse" or "husband and wife" in this Plan will include a reference to same-sex domestic partners.

Section 1.31 "Termination Date" shall mean the date on which an Employee's employment terminates for any reason.

Section 1.32 "University" shall mean The Trustees of the University of Pennsylvania.
ARTICLE II

PARTICIPATION

Section 2.1 General Requirements.

(a) Each Eligible Employee who was a Participant in any of the Plans on June 30, 2021, shall be eligible to continue participation in such Plans as of the Effective Date, if he or she continues to be an Eligible Employee. Subject to 1.12, each other Eligible Employee shall be eligible to make an election to be covered under a Plan as of the later of the Effective Date or the date described below:

1. \( \text{(1) with respect to the Medical Plan, Dental Plan and Vision Plan:} \)
   \( \text{(i) as of the first date of employment for those who commence employment on the first of the month; or} \)
   \( \text{(ii) as of the first of the month following the month in which employment commences for those who commence employment any time other than the first of the month;} \)

2. \( \text{(2) with respect to the Dependent Life Insurance Plan, as soon as administratively practicable following an election to participate;} \)

3. \( \text{(3) with respect to the Health Care Pre-Tax Expense Account Plan, as soon as administratively practicable following an election to participate;} \)

4. \( \text{(4) with respect to the Dependent Care Pre-Tax Expense Account Plan, as of the first payroll period following one year of employment and the attainment of age 21;} \)

5. \( \text{(5) with respect to the Long-Term Disability Plan and the Group Life Insurance Plan, as of the Employment Commencement Date; and} \)

6. \( \text{(6) with respect to the Long-Term Care Plan, as of the first of the following month;} \)

provided, however, that until the Eligible Employee makes an election the amount of coverage in effect under each Plan shall be the default amount, if any, described in the applicable Appendices.

Notwithstanding the foregoing, an Eligible Employee who is a visiting faculty member becomes a Participant on his or her Employment Commencement Date.

(b) In applying the Program's eligibility requirements, the following rules shall apply:
(1) Any requirement that an Eligible Employee satisfy a waiting period or complete an employment requirement shall not be affected by a period of approved unpaid absence.

(2) If an Eligible Employee is absent from work on the date he or she would become a Participant as described in this Section 2.1 (other than as a result of an absence due to a health-related factor), such Eligible Employee will not become a Participant for the purposes of the Medical Plan, Dental Plan and Vision Plan until the date he or she returns to work.

(3) If an Eligible Employee is absent from work on the date he or she would become a Participant as described in this Section 2.1, such Eligible Employee will not become a Participant for the purposes of the Group Life Insurance Plan until the date he or she returns to work.

(4) Coverage for a Dependent shall commence as of the date on which the Eligible Employee becomes eligible for coverage or the date as of which coverage is effective under Section 2.7 or 5.6, as applicable, provided the Eligible Employee elects coverage for such Dependent in a timely manner under such Section. With respect to the Medical Plan, enrollment shall be permitted later than the date specified in Section 2.7 or 5.6, provided the Eligible Employee completes the necessary enrollment forms within 120 days of the date the Dependent was otherwise eligible for coverage. In such a case, coverage shall be retroactive no more than 60 days prior to such late enrollment and contributions for such retroactive period shall be made with After-Tax Contributions.

(c) In order to receive benefits under any of the Plans, a Participant must meet any eligibility requirements set forth in the appropriate Plan as well as the eligibility requirements of any Contract incorporated by the terms of the Program, and, to the extent required, have made any applicable elections under Articles IV (Contributions and Benefits) and V (Election Procedures).

Section 2.2 Cessation of Coverage for Participants. Subject to the provisions of Section 4.11, and except for the right to continue coverage under Article III or as otherwise provided in the applicable Appendix or Contract, coverage for a Participant shall cease on the earliest of:

(a) with respect to the Medical Plan, Dental Plan and Vision Plan, as of the last day of the month in which termination or ineligibility occurs for those who terminate employment or become ineligible on the first through the fifteenth of the month;
(b) with respect to the Medical Plan, Dental Plan and Vision Plan, as of the last day of the month following the month in which termination or ineligibility occurs for those who terminate employment or become ineligible on the sixteenth through the thirty-first of the month;

(c) with respect to the Group Life Insurance Plan, Dependent Life Insurance Plan, Long Term Disability Plan, Health Care Pre-Tax Expense Account Plan and Long Term Care Plan, as of the date on which termination or ineligibility occurs;

(d) with respect to the Dependent Care Pre-Tax Expense Account Plan, as of the last day of the Plan Year in which termination or ineligibility occurs, although contributions end with the Participant's final paycheck;

(e) with respect to a particular Plan, the date as of which such Participant ceases participation pursuant to Section 2.5;

(f) with respect to benefits toward the cost of which the Participant is required to contribute under Article IV, the date as of which such Participant fails to make such required contributions or exhausts the Contributions allocated to purchase such benefit, if later; or

(g) the date as of which the Program is terminated under Section 8.2 with respect to such Participant.

(h) Notwithstanding the foregoing, in the sole discretion of, and upon the terms prescribed by the Plan Administrator, a Participant who terminates employment but receives severance pay from the Employer in the form of periodic payments shall be subject to the following rules:

(1) Coverage for such Participant under the Medical Plan, Dental Plan, Vision Plan and Health Care Pre-Tax Expense Account Plan shall continue through the last day of the month in which severance pay ends, subject to the payment of any applicable Section 125 Contributions from the Participant's severance payments. Notwithstanding the foregoing, coverage under the Health Care Pre-Tax Expense Account Plan shall not continue beyond the end of the Plan Year in which such termination occurs.

(2) Coverage for such Participant shall terminate under the Group Term Life Insurance Plan and the Dependent Life Insurance Plan, subject to any conversion rights under the applicable Contract.

(3) Coverage for such Participant shall terminate under the Dependent Care Pre-Tax Expense Account.

Notwithstanding the foregoing, the University may, in its sole discretion, cause a Participant's coverage under the Program to terminate if such Participant provides false information or makes misrepresentations in connection with a claim for benefits; permits a nonparticipant to use a membership or other identification card for the purpose of wrongfully obtaining benefits; obtains
or attempts to obtain benefits by means of false, misleading or fraudulent information, acts or
omissions; fails to make any copayment, supplemental charge, or other amount due with respect
to a benefit; behaves in a manner disruptive, unruly, abusive, or uncooperative to the extent that
the Program is unable to provide benefits to him or her; or threatens the life or well-being of
personnel administering the Program or of providers of services or benefits.

Section 2.3  Cessation of Coverage for Dependents. Subject to the provisions of
Section 4.11, and except for the right to continue coverage under Article III or as otherwise
provided in the applicable Appendix or Contract, coverage for a covered Dependent shall cease
on the earliest of:

(a) with respect to any benefit, the date on which such dependent ceases to be
classified as a Dependent under the Program or the applicable Appendix or Contract, except that
coverage under the Medical Plan, the Dental Plan and the Vision Plan shall continue until the last
day of the month in which a Dependent ceases to be a Dependent due to attainment of age 26;

(b) the date provided in Section 2.2 on which the Participant covering such
individual as a Dependent ceases to be a Participant;

(c) with respect to benefits toward the cost of which the Participant is required
to contribute under Article IV, the date as of which such Participant fails to make such required
contributions or exhausts the Contributions allocated to purchase such benefit, if later; or

(d) the date as of which the Program is terminated under Section 8.2 with
respect to such individual.

Notwithstanding the foregoing, the University may, in its sole discretion, cause a dependent's
coverage under the Program to terminate if such dependent provides false information or makes
misrepresentations in connection with a claim for benefits; permits a nonparticipant to use a
membership or other identification card for the purpose of wrongfully obtaining benefits; obtains
or attempts to obtain benefits by means of false, misleading or fraudulent information, acts or
omissions; fails to make any copayment, supplemental charge, or other amount due with respect
to a benefit; behaves in a manner disruptive, unruly, abusive, or uncooperative to the extent that
the Program is unable to provide benefits to him or her; or threatens the life or well-being of
personnel administering the Program or of providers of services or benefits.

Section 2.4  Recomencement of Participation.

(a) A former active Participant who again becomes an Eligible Employee
shall recommence participation on his or her Reemployment Commencement Date in accordance
with the provisions of Section 2.1 as if he or she had not been previously employed.

(b) In the event a change of job classification results in a Participant no longer
qualifying as an Eligible Employee, such person shall cease to be a Participant in accordance
with Section 2.2. Should such Employee again qualify as an Eligible Employee, he or she shall
become a Participant as of the date of such requalification and shall make new benefit elections
in accordance with procedures established by the Plan Administrator.
(c) Notwithstanding the foregoing, if a Participant who terminates employment but receives severance pay from the Employer in the form of periodic payments has a Reemployment Commencement Date on or prior to the cessation of severance pay he or she shall not be treated as having terminated service and all elections that continued under Section 2.2(h)(1) shall continue and all elections that terminated under Section 2.2(h)(2) and (3) may be reelected.

(d) A Participant who is reemployed during the Plan Year after a bona fide termination of employment may make new benefit elections, subject to Section 5.6.

Section 2.5 Coverage During a Period of Disability or Leave of Absence. Subject to Section 5.6 and except as provided in Section 2.5(c), if an Eligible Employee is unable to work due to a disability or is on a leave of absence (only to the extent provided in the written personnel policies and practices of the Participating Employer), participation in the Plans shall continue as follows:

(a) Paid Leave of Absence. If the Eligible Employee is on an approved personal or medical leave of absence with pay, he or she shall continue to participate in the Plans as if he or she were actively employed for a period not to exceed 24 months.

(b) Unpaid Leave of Absence. If an Eligible Employee is on a leave of absence without pay, participation in the Plans shall continue (but not more than 24 months) as follows:

1. Medical Plan, Dental Plan and Vision Plan. If the Eligible Employee is on an approved personal or medical leave of absence without pay, he or she shall continue to participate in the Medical Plan, Dental Plan and Vision Plan as if he or she were actively employed, including the payment of any required contributions (which shall be After-Tax Contributions at the active employee rate for an period of Family and Medical Leave and at the rate of 100% of the Applicable Cost (within the meaning of Section 3.1(a)) for any other type of approved leave), unless the Eligible Employee elects to terminate coverage during such leave of absence.

2. Group Life Insurance Plan and Dependent Life Insurance Plan. If the Eligible Employee is on an approved personal or medical leave of absence without pay, he or she shall continue to participate in the Group Life Insurance Plan and Dependent Life Insurance Plan as if he or she were actively employed, including the payment of the full cost of coverage with After-Tax Contributions, unless the Eligible Employee elects to terminate coverage during such leave of absence.

3. Health Care and Dependent Care Pre-Tax Expense Account Plans. If the Eligible Employee is on an approved personal or medical
leave of absence without pay (only to the extent provided in the written personnel policies and practices of the Participating Employer), his or her participation in the Health Care and Dependent Care Pre-Tax Expense Account Plans shall cease. The Eligible Employee shall have the option to continue coverage under Health Care Pre-Tax Expense Account Plan pursuant to Article III.

(4) Long-Term Disability Plan. If the Eligible Employee is on an approved personal or medical leave of absence without pay (only to the extent provided in the written personnel policies and practices of the Participating Employer), he or she shall continue to participate in the Long-Term Disability Plan as if he or she were actively employed.

(5) Long Term Care Plan. If the Eligible Employee is on an approved personal or medical leave of absence without pay, he or she shall continue to participate in the Long Term Care Plan as if he or she were actively employed, including the payment of the full cost of coverage with After-Tax Contributions, unless the Eligible Employee elects to terminate coverage during such leave of absence.

(6) Full-Time Faculty. Notwithstanding the foregoing, benefits for Full-time Faculty will be determined as provided in accordance with the University's written personnel policies and practices.

(c) Long-Term Disability Plan. An Eligible Employee receiving benefits under the Long-Term Disability Plan shall cease to be a participant under the Program and shall receive coverage as provided under the University's Retiree Health Plan.

(d) Coordination with Federal Law. Notwithstanding the foregoing, participation under the Program shall continue or recommence as required by applicable federal law (including but not limited to, the Family and Medical Leave Act of 1993 and the Uniformed Services Employment and Reemployment Rights Act of 1994).

(e) Workers Compensation. Notwithstanding the foregoing, an Eligible Employee who is receiving benefits under any workers compensation law shall continue to participate in the Medical Plan, Dental Plan and Vision Plan as if he or she were actively employed for a period of 12 months. Thereafter, coverage may be continued under Article III.

Section 2.6 Exclusions. The University may prohibit any Employees of a division of the University or any Employees of a Participating Employer from being eligible for specific options or coverages under any of the Plans.

Section 2.7 Special Enrollment Rights.
(a) If an Eligible Employee declines enrollment for himself or herself, his or her Spouse or his or her Dependents because of other health insurance coverage, he or she shall be able to enroll himself or herself, and his or her Spouse and his or her Dependents in the Medical Plan, provided that a request for enrollment is made within 30 days after such other coverage ends and such other coverage was lost due to (i) the loss of eligibility for such other coverage, (ii) the cessation of employer contributions for such other coverage, or (iii) the exhaustion of COBRA coverage.

(b) If an Eligible Employee adds a new Dependent as a result of marriage, birth, adoption or placement for adoption, the Eligible Employee shall be able to enroll himself or herself, his or her new Spouse and/or his or her new Dependents, if otherwise eligible, provided that a request for enrollment is made within 30 days after the marriage, birth, adoption or placement for adoption. Coverage shall commence on the first day of the month following the date on which the Eligible Employee completes the necessary enrollment forms. In the case of an enrollment due to birth, adoption or placement for adoption, coverage shall commence as of the date of such birth, adoption or placement for adoption and continue for a period of 30 days thereafter, but continued coverage beyond that date shall require that the Eligible Employee completes the necessary enrollment forms within 30 days of such birth, adoption or placement for adoption.

(c) If an Employee (or a Dependent of an Employee) (1) loses Medicaid or the Children's Health Insurance Program ("CHIP") coverage as a result of a loss of eligibility for such coverage or (2) becomes eligible for a premium assistance subsidy under Medicaid or CHIP, such Employee shall be able to enroll himself or herself, and his or her Spouse and his or her Dependents in the Medical Plan, provided that a request for enrollment is made within 60 days after the loss of such coverage or premium assistance eligibility.
ARTICLE III

CONTINUATION OF COVERAGE

Section 3.1  Definitions. For purposes of this Article and Appendix E, the following terms shall have the meanings set forth below:

(a)  "Applicable Cost" means, with respect to any period of continued coverage, the cost to the Program for such period of coverage for a Similarly Situated Beneficiary to whom a Qualifying Even has not occurred.

(b)  "COBRA Continuation Coverage" means the continuation of the Health Benefits being provided to a Participant or a Qualified Beneficiary immediately prior to a Qualifying Event.

(c)  "Election Period" means a period of at least 60 days' duration that begins not later than the date on which the Qualified Beneficiary's coverage under the Program would otherwise terminate by reason of a Qualifying Event and that ends 60 days after the later of: (i) the date such coverage would otherwise end, or (ii) the date that the Qualified Beneficiary receives notice of his or her right to continued coverage under the Program pursuant to Section 3.5.

(d)  "Health Benefit" means a benefit paid pursuant to the provisions of the Medical Plan, the Dental Plan, the Vision Plan or the Health Care Pre-Tax Expense Account Plan.

(e)  "Qualified Beneficiary" means the former Participants, Spouses, former Spouses and children of Participants described in Sections 3.2, 3.3 and 3.4 and any child born to, adopted by, or placed for adoption with a former Participant during the period of COBRA Continuation Coverage.

(f)  "Qualifying Event" means any of the following events which, but for this Article, would result in the loss of coverage of a Qualified Beneficiary:

(1)  the death of a Participant;

(2)  the termination (other than by reason of gross misconduct) of a Participant's employment or a reduction in his or her hours;

(3)  the divorce or legal separation of a Participant and his or her Spouse;

(4)  a Participant becoming entitled to Medicare benefits; or

(5)  a Dependent child of a Participant ceasing to be classified as a Dependent.
(g) "Similarly Situated Beneficiary" means, in the case of any Qualified Beneficiary who has a Qualifying Event, an individual who has the same coverage options under the Health Benefit that the Qualified Beneficiary would have had if the Qualifying Event had not occurred; provided that determinations of similar status shall be made by the Employer in accordance with and taking into account the factors permitted under section 4980B of the Code and the regulations issued thereunder to the extent such law or regulations apply.

Section 3.2 COBRA Continuation Coverage for a Participant. A Participant who no longer qualifies for Health Benefit coverage because of his/her termination of employment or a reduction in the number of hours that he/she works may elect COBRA Continuation Coverage under the Program pursuant to this Article. A Participant may also elect COBRA Continuation Coverage for his or her Dependents who no longer qualify for Health Benefit coverage due to the Participant's termination of employment or reduction in work hours. COBRA Continuation Coverage may not be elected under the Program, however, if the Plan Administrator determines, in its sole discretion, that the Participant was terminated for reasons of gross misconduct.

Section 3.3 COBRA Continuation Coverage for a Dependent. A Dependent may elect COBRA Continuation Coverage under the Program pursuant to this Article if the Dependent is no longer eligible for Health Benefits because:

(a) the Participant dies;

(b) the Participant and his/her Spouse become divorced or legally separated;

(c) the Participant becomes entitled to receive Medicare benefits (that is, the Participant has elected Medicare as the primary payor); or

(d) a child Dependent ceases to be classified as an eligible Dependent.

Section 3.4 Period of Coverage. A Qualified Beneficiary who elects COBRA Continuation Coverage under the Program shall be provided coverage identical to that being provided at that time to a Similarly Situated Beneficiary. The period of COBRA Continuation Coverage shall be determined as follows:

(a) Qualified Beneficiaries under Sections 3.2 or 3.4(a) shall be provided COBRA Continuation Coverage for up to 18 months. An additional 11-month period of COBRA Continuation Coverage will be provided to all Qualified Beneficiaries in a family unit if any such Qualified Beneficiary is determined, under Title II or Title XVI of the Social Security Act, to have been disabled at any time during the first 60 days of COBRA Continuation Coverage, provided the Plan Administrator is notified in writing by the disabled Qualified Beneficiary of such determination within 60 days of the determination and prior to the end of the initial 18-month period. The 11-month extension does not apply to a Participant's same-sex domestic partner or his or her children.

(b) Qualified Beneficiaries under Section 3.3 shall be provided COBRA Continuation Coverage for up to 36 months.
(c) If a Qualified Beneficiary, other than a former Participant, who is receiving COBRA Continuation Coverage under Section 3.2 would lose Health Benefits during the 18- or 29-month period because of a second Qualifying Event described in Section 3.1(f)(1), (3), (4) or (5), COBRA Continuation Coverage will be provided for up to 36 months.

(d) If a Participant becomes entitled to benefits under Medicare and then during the subsequent 18-month period loses Health Benefits due to a Qualifying Event described in Section 3.1(f)(2), COBRA Continuation Coverage for Qualified Beneficiaries other than the Participant shall be provided for not less than 36 months following the Participant's entitlement to Medicare.

(e) Notwithstanding the foregoing, COBRA Continuation Coverage under the Health Care Pre-Tax Expense Account Plan shall in no event extend beyond the last day of the Plan Year in which the Qualifying Event occurs.

(f) Notwithstanding the foregoing, COBRA Continuation Coverage shall end prior to the expiration of the 18-, 29- or 36-month period on the date that any of the following events occur:

1. the date on which the Employer ceases to provide any group health plan to any Employee;

2. the date on which COBRA Continuation Coverage ceases by reason of the Qualified Beneficiary's failure to pay the required premium pursuant to Section 3.6;

3. the date, after the date of his or her election of COBRA Continuation Coverage, on which the Qualified Beneficiary becomes covered under another group health plan, unless the Qualified Beneficiary has a medical condition at the time new coverage is effective that is subject to an exclusion or limitation under the terms of the new plan (other than an exclusion or limitation which does not apply to (or is satisfied by) such Qualified Beneficiary by reason of section 9801, et seq. Of the Code, section 701, et seq. of ERISA, or Title XXVII of the Public Health Service Act);

4. the date, after the date of his or her election of COBRA Continuation Coverage, on which the Qualified Beneficiary becomes entitled to Medicare benefits; or

5. if the Qualified Beneficiary is receiving extended coverage for disabled individuals described above, the date the Qualified Beneficiary is no longer entitled to Social Security disability benefits.
(a) Qualified Beneficiaries must notify the Plan Administrator of a divorce, separation or change in the status of a Dependent. In addition, Qualified Beneficiaries must notify the Plan Administrator within 60 days after the date of any final determination under Title II or XVI of the Social Security Act that the Qualified Beneficiary is disabled, but prior to the expiration of the 18-month COBRA Continuation Coverage period. Qualified Beneficiaries must also notify the Plan Administrator within 30 days after the date of any final determination under Title II or XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled.

(b) The Employer must notify the Plan Administrator of the death of an Employee, termination of an Employee or a reduction in the Employee's hours, if an Employee becomes entitled to Medicare benefits, or of any bankruptcy proceeding.

(c) The Plan Administrator must receive the notice set forth in subsections (a) and (b) from the Employer within 30 days of the event or from the Qualified Beneficiary within 60 days of the event.

(d) Within 14 days of its receipt of any notice required by subsection (a) or (b) of this Section, the Plan Administrator shall notify the Qualified Beneficiary of his or her right to COBRA Continuation Coverage under the Plan. Any notification to a Spouse or former Spouse by the Plan Administrator shall also be treated as notification to all other Qualified Beneficiaries residing with said Spouse at the time such notification is made. Notice from the Plan Administrator shall be deemed complete upon placement of the notice of Election Period in the United States mail, provided there is sufficient postage for first class mailing and said notice is addressed to the Qualified Beneficiary's last known primary residence (any address other than the Qualified Beneficiary's last known primary residence shall only be known to the Plan Administrator if the Qualified Beneficiary specifically notifies the Plan Administrator of the change in address).

(e) Any notice or election given or made by a Qualified Beneficiary under this Section 3.5 shall be in writing in accordance with procedures established by the Plan Administrator.

Section 3.6 Election of Coverage. Upon notification by the Plan Administrator of his or her right to COBRA Continuation Coverage under the Program, a Qualified Beneficiary must affirmatively elect COBRA Continuation Coverage before the expiration of the Election Period. Unless otherwise specified in the election, an election by a Spouse or former Spouse of COBRA Continuation Coverage under the Program shall also be considered an election for any Dependent children who would also lose coverage because of the same Qualifying Event. An election by a former Participant of COBRA Continuation Coverage under the Program shall also be considered an election by all Dependents of that former Participant who would also lose coverage because of the same Qualifying Event. In general, the Qualified Beneficiary shall not be able to change options under the Medical Plan, unless he or she is in a region-specific option and is moving out of the applicable service area. In this case, the Qualified Beneficiary can elect a suitable alternate Medical Plan option.

Section 3.7 Contributions Required. A Qualified Beneficiary who elects COBRA Continuation Coverage under the Program may be required to pay a premium for any period of
continued coverage. The amount of the premium and the payment schedule shall be determined by the Plan Administrator, in its sole discretion, but in no event shall any premium for a period of continued coverage exceed 102% of the Applicable Cost for that period or, in the case of the 11 month extension for disability, 150% of the Applicable Cost for that period. Notwithstanding any payment schedule devised by the Plan Administrator, a Qualified Beneficiary may elect to pay his or her premium in the form of monthly installments. To be effective, however, any such election must be made prior to the expiration of the Election Period. If an election of COBRA Continuation Coverage is made, the premium payment for the period of continued coverage preceding the date of the election must be made within 45 days from the date of the election. A Qualified Beneficiary shall not be reinstated as a Participant until the full premium due and owed by the Qualified Beneficiary is received by the Plan Administrator or its delegate.

Section 3.8 Form of Contributions. To fund Health Benefits elected by a Qualified Beneficiary under Section 3.2 or 3.3, After-Tax Contributions shall be made directly by the Qualified Beneficiary to the Employer, the Employer's designated agent, or the Insurer. Amounts so contributed shall be allocated to a separate After-Tax Contributions Account to provide such person's COBRA Continuation Coverage. No Flex Dollar Credits shall be provided on behalf of any Qualified Beneficiary under this Article III.

Section 3.9 Continuation During Military Service. Notwithstanding anything in this Article III to the contrary, Eligible Employees and Dependents who lose Health Benefits due to the Eligible Employee's military leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 may elect to continue such coverage for up to 24 months. Any individual who elects to continue such coverage will be required to make the same premium payments as a Qualified Beneficiary, except that the premium shall in no event not exceed 102% of the Applicable Cost.

Section 3.10 Compliance with Contracts. Notwithstanding anything to the contrary herein, COBRA Continuation Coverage shall be provided in accordance with the terms of the applicable Contract or Appendix and the procedures of the Insurer to the extent that the Contract, Appendix and procedures do not violate the provisions of section 4980B of the Code and applicable regulations thereunder.

Section 3.11 Certificate of Creditable Coverage. The Plan Administrator shall provide to each Participant or Dependent who loses coverage under the Plan a certificate described in section 701(e) of ERISA setting forth his or her period of creditable coverage (as defined in section 701(c)(1) of ERISA) under the Plan. Such certificate shall be provided not later than the time an election form and explanation of COBRA Continuation Coverage is required under Section 3.4. If a Participant or Dependent elects COBRA Continuation Coverage under Section 3.5, a certificate described in section 701(e) of ERISA shall be provided at the conclusion of such coverage.
ARTICLE IV

CONTRIBUTIONS AND BENEFITS

Section 4.1 Contributions. The amount of Contributions to the Plan for a Plan Year shall be the sum of the Participant's Flex Dollar Credit, Participant Contributions, and the incentive for electing no coverage as described in subsections (a), (b) and (c) below. In the case of a Participant who participates in the Program or a part of the Program for less than a full Plan Year, the amount of Contributions for the Program or a part of the Program shall be prorated according to the number of calendar months of participation.

(a) Flex Dollar Credit. A Participant's Flex Dollar Credit, if any, shall be determined as set forth in Section 1.18. Flex Dollar Credits shall be treated as additional Compensation from which the Participant may make After-Tax Contributions or Section 125 Contributions.

(b) Participant Contributions. As a condition of participation, the Compensation of each Participant shall be adjusted as provided below, and the amount of such adjustment shall be available as Contributions to the Program. The amount of such adjustment shall be:

(1) the amount necessary for the Participant to purchase the coverage elected under Article V for the Plan Year through Section 125 Contributions for:

   (A) the Medical Plan;

   (B) the Dental Plan;

   (C) the Vision Plan;

   (D) the Health Care Pre-Tax Expense Account Plan; and

   (E) the Dependent Care Pre-Tax Expense Account Plan; plus

(2) the amount necessary for the Participant to purchase the coverage elected under Article V for the Plan Year through After-Tax Contributions for:

   (A) the Group Life Insurance Plan;

   (B) the Dependent Life Insurance Plan; and

   (C) the Long Term Care Plan; plus

(3) the amount elected by the Participant to be contributed under a Health Savings Account established with a financial institution that
has been selected by the University to receive Section 125 Contributions in connection with this Program; over

(4) the Participant's Flex Dollar Credit, if any.

(c) Contributions for Visiting Faculty. Notwithstanding the foregoing, all Contributions made by Participants who are visiting faculty shall be made with After-Tax Contributions.

Section 4.2 Commencement of Contributions.

(a) In the case of a Participant enrolling (or reenrolling) in the Program effective with the first day of any Plan Year, the Participant's Contributions shall commence as follows:

(1) to the Participant's Salary Reduction Account and After-Tax Contributions Account as directed by the Participant pursuant to Section 4.5, on the first day of the first pay period beginning in the calendar month (June) next preceding such July 1; and

(2) to the Participant's Health Care Expense Account and Dependent Care Expense Account, as directed by the Participant pursuant to Section 4.5, commencing July 1.

(b) In the case of a Participant who enrolls in the Program effective on a date later than the beginning of a Plan Year, the Participant's Section 125 Contributions shall be applied and Flex Dollar Credit shall accrue commencing with the dates of participation specified in Section 2.1.

(c) Notwithstanding the foregoing, all Contributions made by Participants who are visiting faculty shall be made in the current month.

Section 4.3 Cessation of Contributions.

(a) Irrespective of the commencement date of contributions described in Section 4.2(a) for any Plan Year, the accrual and allocation of benefits to a Participant's Salary Reduction Account and After-Tax Contributions Account shall cease with the last day of the last pay period in May of such Plan Year.

(b) Irrespective of the commencement date of contributions described in Section 4.2(b) for any Plan Year, the accrual and allocation of benefits to a Participant's Health Care Expense Account and Dependent Care Expense Account shall cease with the last day of the last pay period in June of such Plan Year.

Section 4.4 Rate of Accrual of Contributions. Contributions for a Plan Year shall accrue and shall be allocated to benefits ratably for the pay periods determined under Sections 4.2 and 4.3 above.
Section 4.5  Allocation of Contributions. A Participant's Section 125 Contributions and After-Tax Contributions shall be allocated to the Participant's Salary Reduction Account, After-Tax Contributions Account, Health Care Expense Account and Dependent Care Expense Account according to the Participant's election under Article V. Any Contributions not so allocated by the Employee's election (or deemed election) shall be distributed to the Participant as cash compensation for the payroll periods during which such Contributions accrue and shall be included in taxable income subject to any applicable withholding or similar taxes. No benefit under the Plan shall be paid in any manner that defers the receipt of compensation beyond the last day of the Plan Year.

Section 4.6  Agreement to Make Contributions. The agreement entered into by a Participant to make After-Tax Contributions and/or Section 125 Contributions shall be entered into before the beginning of the Plan Year for which it will be effective; or for new Participants, the close of the Election Period. The election forms shall be effective as provided in Section 2.1 or 4.2. Each such agreement shall remain in effect until revoked or suspended by reason of any Participant's ceasing to be a Participant, provided that no agreement may be revoked by any Participant during the Plan Year for which it is effective, except as provided in Section 5.6, and, with respect to Plan Years following the Plan Year for which the agreement is first effective, shall remain effective to the extent necessary to provide the benefits described in Section 5.4, if any. Any Participant who fails to enter into an agreement to make Contributions shall be deemed to have elected default coverage provided under each Plan. Notwithstanding anything in the Plan to the contrary, the Employer may adjust a Participant's agreement to the extent necessary to provide the benefits elected or deemed elected by the Participant.

Section 4.7  Funding. Benefits shall be funded by the Employer and administered and/or insured in accordance with the applicable Contract by an insurance company and/or claims administrator selected by the Employer. A portion of the costs of such benefits shall be paid by the Participant's contributions in accordance with this Plan and in such amounts as are determined annually by the Employer prior to the Election or Reelection Period. All other costs shall be paid by the Employer. All Contributions shall be held in the Employer's general assets, by an Insurer pursuant to a Contract forming a part of the Plan or in a trust established for the purpose of funding benefits under the Plan. The Employer shall determine whether and to what extent the Contributions shall be held by the Employer, by an Insurer under a Contract or in a trust.

Section 4.8  Forfeitures. If total benefits reimbursed to a Participant for expenses incurred during the Plan Year are less than the amounts allocated to the Health Care Pre-Tax Expense Account Plan or amounts allocated to the Dependent Care Pre-Tax Expense Account Plan, the unused portion shall be forfeited and shall become general assets of the applicable Employer. No Participant shall be entitled to:

(a) carry over any unused portion of his or her accounts to the succeeding Plan Year;

(b) reallocate the unused portion to any other benefit; nor

(c) receive any unused benefits in the form of additional cash.
Such amounts shall be used to defray administrative costs of the Program and, to the extent of any excess, shall be used to reduce Employer Contributions under the Program as may be permitted by Treasury regulation.

Section 4.9 Insurance Contracts. Some or all of the benefits provided under the Plan may, at the discretion of the University, be provided by the purchase of one or more Contracts. Any dividends or retroactive rate or other refunds, which may become payable under any Contracts or benefit programs due to actuarial error in rate calculation or experience gains, shall be the property of and shall be retained by the University.

Section 4.10 Payment of Benefits. A Participant's eligibility for benefits under any of the Plans shall be determined in accordance with the provisions of each applicable Plan, as well as in accordance with the terms of the applicable Contract, if any, which terms are incorporated herein by reference.

Section 4.11 Termination of Employment. If a Participant's employment terminates for any reason, he or she (or his or her beneficiary, in the event of the Participant's death) or his or her Dependent may continue to make claims for benefits under the Plans, to which the Participant or Dependent would otherwise be entitled under the terms of the individual Plan and the Contracts incorporated therein. Claims for benefits shall be made in the manner set forth in the Program and in the applicable Contracts.
ARTICLE V

ELECTION PROCEDURES

Section 5.1  Election to Participate.

(a)  General. During the applicable Election Period or Reelection Period, a Participant shall elect to participate in the Plan by choosing, in accordance with the procedures described in Section 5.2 or 5.3, the coverage desired under each Plan. A Participant may elect no coverage for a particular Benefit to the extent provided in the Appendices. The minimum and maximum amounts of coverage that may be elected under the Plans for the Plan Year are the minimum and maximum amounts described in the individual Plan Appendix. The types and amounts of benefits available under the Plans, the eligibility requirements for each benefit in the Plans, and the other terms and conditions of coverage and benefits under the Plans are as set forth in the applicable Appendices and in the Contracts that are incorporated by reference therein.

(b)  Election Procedures. All elections under the Plan (including, without limitation, elections to begin or change participation in the Plan, to elect levels and types of Plan benefits, to designate beneficiaries, and otherwise) shall be made in accordance with the uniform and nondiscriminatory procedures established, in their sole discretion, by the Plan Administrator or its delegates, which, for these purposes shall include any Insurer or other provider selected by the Plan Administrator to provide benefits or other services to the Plan. Without limiting the foregoing, the Plan Administrator or its delegates may establish uniform and nondiscriminatory procedures relating to Plan elections that provide for (1) elections to be made through electronic or other paperless means, (2) a Participant and/or his Dependents or beneficiaries to be defaulted to a particular election or outcome if they fail to make (or change) an affirmative election, or (3) such other processes and procedures as the Plan Administrator or its delegates may determine in their sole discretion.

Section 5.2  Current Participants. During the applicable Election Period or Reelection Period, the Plan Administrator shall provide or make available enrollment materials to each Participant and to each other Eligible Employee who is eligible to become or continue as a Participant at the beginning of the Plan Year. Each Participant who elects to participate in one or more of the Plans for the Plan Year shall specify the type and level of coverage desired and shall agree to make any applicable Section 125 Contributions and/or After-Tax Contributions. The election process must be completed in accordance with procedures established by the Plan Administrator prior to the end of the Election or Reelection Period. Any elections made by the Participant shall be effective as of the first day of the next following Plan Year.

Section 5.3  New Participants. As soon as practicable before an Eligible Employee becomes a Participant under Section 2.1, the Plan Administrator shall provide or make available to the Eligible Employee the materials described in Section 5.2. If the Eligible Employee desires to participate in one or more of the Plans for the balance of the Plan Year, he or she shall so specify the type and level of coverage desired and shall agree to make any applicable Section 125 Contributions and/or After-Tax Contributions. The election process must be completed in
accordance with procedures established by the Plan Administrator prior to the end of the Election Period. Any elections made by the Eligible Employee shall be effective on the date set forth in Section 2.1.

Section 5.4 Failure to Elect. An Eligible Employee failing to complete the election procedure established by the Plan Administrator during the Election Period for the initial Plan Year in which he or she becomes a Participant, or any Eligible Employee failing to specify an amount of coverage under any Plan (except where the Participant specifies no coverage), shall be deemed to have elected the default coverage provided under each Plan and any applicable Contract. A Participant failing to complete the election procedure established by the Plan Administrator for any Plan Year after his or her initial Plan Year, shall be deemed to have made the same election for the current Plan Year as was in effect immediately prior to the end of the preceding Plan Year. Where specific options or coverages are no longer available, the Plan Administrator, in its discretion, may substitute similar options or coverages.

Section 5.5 Nondiscrimination Requirement. With respect to eligibility, contributions and benefits, the Program shall satisfy the nondiscrimination provisions of section 125 of the Code to the extent applicable. The University may prospectively limit, reallocate or deny any benefits to the extent necessary to avoid any such discrimination.

Section 5.6 Modification and Revocation of Elections. Elections made under the Program (or deemed to be made under Section 5.4) may be changed during the Plan Year only in accordance with the following rules:

(a) Change in Status. An Eligible Employee may make a new benefit election if both the revocation of the existing benefit election and the election of new benefits are on account of and correspond with a change in status. The following events shall constitute a change in status:

1. events that change an Eligible Employee's legal marital status, including marriage, death of Spouse, divorce, legal separation, or annulment;

2. events that change an Eligible Employee's number of Dependents, including birth, adoption, placement for adoption, determination of custody, or death of a Dependent;

3. events that change the employment status of the Eligible Employee or, the Eligible Employee's Dependent, including a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of the Program or the benefit plan of the Eligible Employee's Dependent are contingent on the Employee's or Dependent's employment status and there is a change in that employment status that causes the individual to become eligible or ineligible under the plan (e.g., transfer from a full-time to a part-time position), then the change
will constitute a change in employment status for purposes of this Section 5.6;

(4) an event that causes an Eligible Employee's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(5) a change in the place of residence of the Eligible Employee or the Eligible Employee's Dependent.

(b) **Special Enrollment Rights.** An Eligible Employee may revoke an election with respect to accident or health coverage during the Plan Year and make a new election that corresponds with the special enrollment rights provided in section 9801(f) of the Code, whether or not the change in election would be permitted under subsection (a) above.

(c) **Judgment, Decree, or Order.** An Eligible Employee may revoke a benefit election and make a new benefit election if a change in accident or health coverage for the Eligible Employee's child or foster child who is a Dependent of the Eligible Employee is required by a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order as defined in section 609 ERISA, as amended). The Eligible Employee may (i) change his or her election to provide coverage for the child if the order requires coverage under an accident or health plan covering the Eligible Employee, or (ii) cancel coverage for the child if the order requires the Spouse, former Spouse or other individual to provide coverage.

(d) **Entitlement to Medicare or Medicaid.** If an Eligible Employee, Spouse, or Dependent who is enrolled in an accident or health plan of the University becomes entitled to coverage (i.e., becomes enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Eligible Employee may make a prospective election change to cancel coverage of the Eligible Employee, Spouse, or Dependent under that plan. In addition, if an Eligible Employee, Spouse, or Dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the Eligible Employee may make a prospective election to commence or increase coverage of the Eligible Employee, Spouse or Dependent under such accident or health plan.

(e) **Significant Cost Changes.** If the cost of benefits coverage under the Program should change significantly, the following shall apply:

(1) **Automatic Changes.** If the cost of benefits under a Plan increases (or decreases) during a Plan Year, the Program may, on a reasonable and consistent basis, automatically implement a prospective increase (or decrease) in the Section 125 Contributions or After-Tax Contributions affected Participants, as applicable.

(2) **Significant Cost Increases.** If the cost of benefits under a Plan significantly increases during a Plan Year, Participants will be
entitled to make a corresponding prospective increase in their Section 125 Contributions or After-Tax Contributions, as applicable. Alternatively, Participants may be allowed to revoke their elections and to receive, on a prospective basis, coverage under another benefit option providing similar coverage.

(3) **Dependent Care Pre-Tax Expense Account Plan.** In the case of the Dependent Care Pre-Tax Expense Account Plan, if a change in cost is imposed by a day care provider who is not a relative of the Participant, the Participant shall be entitled to modify the amount of his or her Section 125 Contribution.

(4) **Health Care Pre-Tax Expense Account Plan.** This subsection (e) shall not apply to the Health Care Pre-Tax Expense Account Plan.

(f) **Significant Coverage Changes.** If benefits coverage under the Program should change significantly, the following shall apply:

(1) **Significant Curtailment.** If the coverage under a Plan is significantly curtailed or ceases during the Plan Year, Participants will be entitled to revoke their elections under the Plan and make a new election on a prospective basis for coverage under another benefit option providing similar coverage. For the purposes of this Section 5.6, coverage under the Medical Plan, Dental Plan or Vision Plan is significantly curtailed only if there is an overall reduction in coverage provided to Participants, so as to constitute reduced coverage to Participants generally.

(2) **Addition (or Elimination) of Benefit Option Providing Similar Coverage.** If during a Plan Year the Program adds a new benefit or other coverage option (or eliminates an existing benefit or other coverage option), Eligible Employees will be entitled to elect the newly added option (or elect another option to replace the eliminated option) prospectively, on a pre-tax basis. Further, the Eligible Employee may make corresponding election changes with respect to other benefit options.

(3) **Dependent Care Pre-Tax Expense Account Plan.** In the case of the Dependent Care Pre-Tax Expense Account Plan, a change in day care provider will constitute a change in coverage that will permit a Participant to modify the amount of his or her Section 125 Contribution.

(4) **Health Care Pre-Tax Expense Account Plan.** This subsection (f) shall not apply to the Health Care Pre-Tax Expense Account Plan.

(g) **Change in Coverage of Dependent Under Another Employer’s Plan.** The Program will permit a Participant to make a prospective election change that is on account of and
corresponds with a change made under the plan of the employer of a Participant's Spouse, former Spouse or Dependent if:

1. the employer of the Participant's Spouse or Dependent permits participants to make an election change that would be permitted under this Section 5.6; or

2. the plan year of the cafeteria plan or qualified benefits plan of the employer of the Participant's Spouse, former Spouse, or Dependent is different from the Plan Year of this Program.

3. Health Care Pre-Tax Expense Account Plan. This subsection (g) shall not apply to the Health Care Pre-Tax Expense Account Plan.

(h) Reduction of Hours During Plan Year. A Participant may make an election change by cancelling health coverage if he or she experiences a reduction of hours below 30 hours per week during a Plan Year and the Participant obtains coverage on a Health Insurance Marketplace/Exchange within two months of the cancellation of coverage under this Plan.

(i) Health Insurance Marketplace Coverage. A Participant may make an election change by cancelling health coverage if he or she experiences a special enrollment period under a Health Insurance Marketplace/Exchange and he or she obtains coverage on a Health Insurance Marketplace/Exchange immediately upon the cancellation of coverage under this Plan.

(j) Effective Date of Election Change. Any change in an election under this Section 5.6 shall be effective as soon as administratively practicable on or after the latest of (i) the date on which the change in status occurs, (ii) the first day of the month beginning after the Eligible Employee changes his or her election in accordance with the election procedure or, in the case of an enrollment due to birth, adoption or placement for adoption, the date of such birth, adoption or placement for adoption; provided the Plan Administrator is notified of the change in status no later than 30 days after such change in status (unless the change in status is divorce or legal separation, in which case the Plan Administrator must be notified within 60 days of the event)), or (iii) the date specified by the Participant in his or her election.

(k) Special Rule for Health Care Pre-Tax Expense Account Plan. A Participant may not modify his or her election under this Section 5.6 so that the anticipated amount allocated to his or her Health Care Pre-Tax Expense Account, will be less than the amount of expenses already reimbursed under that benefit for the Plan Year.

(l) Plan Administrator Discretion. The determination of whether an Eligible Employee has experienced an event that would permit an election change and whether his requested election change is consistent with such event shall be made in the sole discretion of the Plan Administrator.
ARTICLE VI

OTHER RULES

Section 6.1  Benefit Payments to Third Parties. The Plan Administrator may elect to pay benefits directly to a health care provider unless the payment has already been made by the Participant. Where the health care provider rendering services does not have an agreement with the Program to the contrary, the Plan Administrator may, at its election, pay benefits directly to the Participant or other covered individual. In the event the covered individual is deceased, benefits may be paid at the Plan Administrator's option to the covered individual's estate, Spouse, the Participant through whom the individual is covered, or the covered individual's closest relative as determined by the Plan Administrator.

Section 6.2  Designation of Beneficiary. Each Participant shall, in accordance with the procedure established by the Plan Administrator, designate a beneficiary or beneficiaries to receive any payment to which such Participant may be entitled under the Program at the time of his or her death. The Participant shall have the unrestricted right to change such designation, or any subsequent designation, at any time. In the absence of an effective beneficiary designation, any amounts distributable after the death of a Participant shall be paid in accordance with the applicable Contract. As described in more detail in Section 5.1, the beneficiary designation procedures established by the Plan Administrator or its delegates (including any Insurer or other provider that is providing benefits or services to the Plan) may include electronic or online processes and may include rules that provide for the default designation of a beneficiary if a Participant fails to make an affirmative election designating a beneficiary.

Section 6.3  Claims Procedures. The Plan Administrator shall establish reasonable procedures pursuant to which a Participant or Dependent may make a claim benefits under any Plan and appeal any adverse determination on such a claim. Such procedures shall comply with the requirements of section 503 of ERISA and the regulations thereunder and the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 and related guidance.

Section 6.4  Proof of Claim. As a condition of receiving benefits under the Plan, any person may be required to submit whatever proof the University may require (either directly to the University or to any person delegated by it).

Section 6.5  Statute of Limitations. Any lawsuit seeking benefits under this Plan must be brought within two years of the when the person or his or her representative (as applicable) knows or should have known that a claim for benefits has been, or likely would be, denied. The two year shall commence as of the earliest possible date of those described above. In the event that the person does not submit a claim for benefits by the claim filing deadline applicable to a particular benefit, then the claim shall be deemed denied as of the claim deadline and the two-year Statute of Limitations shall begin to run from the applicable claim deadline.

Section 6.6  Coordination of Benefits. Benefits under the Program shall be coordinated between plans, or within this Program, in accordance with the following provisions,
to the extent not inconsistent with the provisions of the applicable Contract. In the case of a conflict, the provisions of the Contract shall control.

(a) **Coordination of Benefits with Other Plans.** Benefits under the Program shall be coordinated, as provided for below, when a Participant or his or her covered Dependent has health coverage under more than one plan, program or other arrangement for the provision of similar benefits. Other coverage shall include (i) coverage under motor vehicle insurance which provides for health insurance protection (including "no-fault" coverage of medical or dental care) where the named insured is given the option of selecting coverage under this Program or the motor vehicle insurance as the primary coverage for certain eligible medical expenses, (ii) governmental benefit programs provided or required by law (such as Medicare), and (iii) other group health plans covering Participants or Dependents, including student coverages provided through a school above the high school level. The Program shall not coordinate benefits with individual health contracts.

1. **General Rule.** A plan that does not coordinate with other plans will be the primary plan.

2. **Covered Individuals.** The benefits of the plan which covers the person as an employee, member or subscriber (other than as a dependent) is the primary plan; the plan which covers the person as a dependent or an individual continuing coverage under section 4980B of the Code is the secondary plan.

3. **Determining Primary Plans.** If both plans cover the individual as a dependent child, the plan covering the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents have the same birthday, the plan covering one of the parents for the longer period of time is the primary plan.

4. **Divorce or Separation.** If both plans cover the individual as a dependent and the parents are separated or divorced, the primary plan will be determined in the following order:
   
   (i) the plan of the parent who has assumed financial responsibility for the child; provided, however, that where the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses and the payer of benefits under the plan that is obliged to pay has actual knowledge of the terms of the decree, that plan is the primary plan;
   
   (ii) the plan of the parent with custody of the child;
   
   (iii) the plan of the stepparent married to the parent with custody of the child; and
(iv) the plan of the parent who does not have custody of the child.

(5) Motor Vehicle Insurance. Notwithstanding any provision in this Program to the contrary, in determining whether this Program or another plan is the primary plan, this Program will be secondary to (i) coverage provided under any "no-fault" coverage of medical or dental care or treatment to the extent required to meet the requirements of any motor vehicle insurance statute or similar statute, and (ii) coverage provided under motor vehicle insurance which provides for health insurance protection, even if the individual selects coverage under the motor vehicle insurance as secondary for eligible medical or dental care or treatment. Thus, if an Employee or Dependent declines to select health care coverage under motor vehicle insurance as primary but such insurance provides health care coverage that purports to be secondary to coverage under the Program, this Program will nevertheless pay benefits second if at all. This provision is expressly intended to avoid the possibility that this Program will be determined to be primary to coverage that is available under motor vehicle or "no-fault" insurance.

(6) The Coordinated Benefit. Benefits provided under this Program will be paid in full when this Program is the primary plan. When this Program is the secondary plan, this Program will provide a benefit so that the combined benefits under both plans will not exceed the amount which would have been paid under this Program if there were no other plan involved.

(b) Coordination When Husband and Wife Are Both Participants. When a husband and wife are both Participants under this Program, each shall be entitled to coverage under this Program as an Employee and neither shall be entitled to coverage as a Dependent of the other Spouse.

(c) Coordination With Medicare. The coordination of benefits between the Medical Plan and Medicare shall be determined in accordance with the following rules:

(1) When a Participant who is an Employee or a covered Spouse becomes eligible for Medicare, his or her participation in the Medical Plan shall continue and the Medical Plan shall be primary unless said individual is eligible for Medicare on the basis of age and elects to have Medicare as his or her primary health care provider. If the Medicare eligible individual makes such an election, his or her coverage under the Medical Plan shall continue only to the extent that coverage is provided for items and services wholly uncovered by Medicare.
(2) When a Participant who is Medicare eligible becomes a former employee or is otherwise no longer eligible for coverage due to a reduction in hours, Medicare shall become his or her primary health care provider regardless of his or her eligibility for COBRA continuation coverage. Similarly, if the Spouse of a previously eligible Participant is Medicare eligible, Medicare will then become the primary health care provider for the Spouse, regardless of his or her COBRA eligibility.

(3) When a non-Spouse dependent of an employee or former employee becomes eligible for Medicare, Medicare shall be his or her primary health care provider.

(4) When a Participant or covered Spouse becomes entitled to Medicare due to total disability, Medicare shall be his or her primary health care provider.

Notwithstanding any provision of this Section 6.6 to the contrary, the Program shall be primary to Medicare only to the extent required by applicable law.

Section 6.7 Third Party Recovery/Reimbursement. The Program's right of recovery in third-party actions shall be determined in accordance with the following provisions, to the extent not inconsistent with the provisions of any applicable Contract, in which case the provisions of the Contract shall control.

(a) In General. When a Participant or Dependent receives Program benefits which are related to medical expenses that are also payable under Workers' Compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, the Participant shall reimburse the Program for the related Program benefits received out of any funds or monies the Participant recovers from any third party.

(b) Specific Requirements and Program Rights. Because the Program is entitled to reimbursement, the Program shall be fully subrogated to any and all rights, recovery or causes of actions or claims that a Participant or Dependent may have against any third party. The Program is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right is regardless of the manner in which the recovery is structured or worded, and even if the Participant or Dependent has not been paid or fully reimbursed for all of their damages or expenses.

The Program's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Program agrees in writing to such reduction. Further, the Program's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund"
doctrine, regulatory diligence or any other equitable defenses that may affect the Program's right to subrogation or reimbursement.

The Program may enforce its subrogation or reimbursement rights by requiring the Participant to assert a claim to any of the benefits to which the Participant or a Dependent may be entitled. The Program will not pay attorneys' fees or costs associated with the claim or lawsuit without express written authorization from the Company.

If the Program should become aware that a Participant or Dependent has received a third-party payment, amount or recovery and not reported such amount, the Program, in its sole discretion, may suspend all further benefits payments related to the Participant and Dependents until the reimbursable portion is returned to the Program or offset against amounts that would otherwise be paid to or on behalf of the Participant or Dependents.

(c) Participant Duties and Actions. By participating in the Program each Participant and Dependent consents and agrees that a constructive trust, lien or an equitable lien by agreement in favor of the Program exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, each Participant and Dependent agrees to cooperate with the Program in reimbursing it for Program costs and expenses.

Once a Participant or Dependent has any reason to believe that the Participant may be entitled to recovery from any third party, the Participant must notify the Program. And, at that time, the Participant (and the Participant's attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Program's subrogation rights and the Program's right to be reimbursed for expenses arising from circumstances that entitle the Participant or Dependent to any payment, amount or recovery from a third party.

If a Participant fails or refuses to execute the required subrogation/reimbursement agreement, the Program may deny payment of any benefits to the Participant or Dependent until the agreement is signed. Alternatively, if a Participant fails or refuses to execute the required subrogation/reimbursement agreement and the Program nevertheless pays benefits to or on behalf of the Participant or a Dependent, the Participant's acceptance of such benefits shall constitute agreement to the Program's right to subrogation or reimbursement.

Each Participant and Dependent consents and agrees that they shall not assign their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Program's consent. As such, the Program's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Program.

Section 6.8 Recovery of Overpayments. In the event that the Program mistakenly pays or overpays a Participant or Dependent, regardless of the reason, the Participant or Dependent shall return such overpayment or mistaken payment to the Program. In the event that a Participant or Dependent fails to return a mistaken payment or overpayment to the Program, the Program and the Employer may suspend all further benefit payments or other payments on any account to the Participant or his or her Dependents until the mistaken payment or
overpayment (along with interest thereon and any expenses associated with such recovery) is returned to the Program or offset against amounts which would otherwise be paid to the Participant or Dependent. The Program, or its designee, may also sue to recover such amounts or use any other lawful remedy to recoup any such amounts.

Section 6.9 Examination of Records. As a condition of receiving benefits under the Program, the Participant and his or her Dependents shall grant the University or its agents the right to examine any medical or hospital records and other records that pertain directly to any case for which benefits are claimed under the Program.

Section 6.10 Medical Child Support Orders. In the event the Plan Administrator receives a medical child support order (within the meaning of section 609(a)(2)(B) of ERISA), the Plan Administrator shall notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Program's procedures for determining whether such an order is a qualified medical child support order (within the meaning of section 609(a)(2)(A) of ERISA). Within a reasonable period the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and alternate recipient of such determination.

Section 6.11 Coordination with Medicaid Provisions. The Program shall comply with the provisions of section 609(b) of ERISA, as follows:

(a) the payment of benefits with respect to a Participant shall be made in accordance with any assignment of rights made by or on behalf of such Participant or a Dependent under the Medicaid laws of any state;

(b) the enrollment of and provision of benefits to a Participant shall be made without regard to the Participant's eligibility for Medicaid under the laws of any state; and

(c) to the extent that payment has been made under the Medicaid laws of any state in a case where the Program has legal liability for such payment, payment of benefits under the Program shall be made in accordance with any state law which provides that such state has acquired the rights of the Participant or a Dependent to such payment.

Section 6.12 Decisions on Health Care. The Medical Plan, Dental Plan and Vision Plan hereunder provide solely for the payment of certain health care expenses. All decisions regarding health care will be solely the responsibility of the Participant and his or her Dependents in consultation with the health care providers selected by the individual. The Program contains rules for determining the percentage of allowable health care expenses that will be reimbursed and whether particular treatments or health care expenses are eligible for reimbursement under the Plan. Any decision with respect to the level of health care reimbursement, or the coverage of a particular health care expense, may be disputed by the covered individual in accordance with the applicable claims procedure under the Program. Each covered individual may use any source of care for health treatment and health coverage as selected by such individual, and neither the Plan nor the Employer shall have any obligation for the cost or liability for the outcome of such care, or as a result of a decision by a covered
individual not to seek or obtain such care, other than liability under the Plan for the payment of benefits.
ARTICLE VII

ADMINISTRATION

Section 7.1 Plan Administrator. Except with respect to those duties assigned an Insurer or other service organization by the Contract applicable to it, the Plan Administrator shall have the authority to control and manage the operation and administration of the Program. The Plan Administrator shall have the exclusive discretionary authority to determine eligibility for benefits under the Program, to construe the terms of the Program and to determine any question (including questions of fact) that may arise in connection with its operation or administration, except to the extent that the Plan Sponsor has authorized the Insurer to make such determinations. Its decisions or actions in respect thereof shall be conclusive and binding upon the Employer and upon any and all Participants, their Dependents, beneficiaries and their respective heirs, distributees, executors, administrators and assignees; subject, however, to the right of the Participant or his or her Dependent or beneficiary to file a written claim under the applicable claims procedures. The Plan Administrator may delegate any of its duties hereunder to one or more of said appointees or to any other person or persons it may designate from time to time.

If the Plan Administrator has not exceeded the time limitations contained in the applicable claims procedure for filing a claims appeal, no person may bring an action against the Plan Administrator in a court of law unless the claims procedure is exhausted and a final determination is made by the Plan Administrator. If the Participant, former Participant, Dependent, former Dependent or other interested person challenges the Plan Administrator's decision, a review by a court of law shall be limited to the facts, evidence and issues presented to the Plan Administrator during the applicable claims procedure. Facts and evidence that become known to the Participants, former Participant, Dependent, former Dependent or other interested person after having exhausted the appeal procedure shall be brought to the Plan Administrator's attention for reconsideration of the appeal in accordance with the time limits established above. Issues not raised with the Plan Administrator during the appeal procedure shall be deemed waived.

Section 7.2 Records. The Plan Administrator shall maintain or cause to be maintained such accounts and records as shall be necessary and appropriate to reflect the administration of the Program and the interests of all Participants and their beneficiaries. Any Participant or his or her beneficiary shall be entitled to examine at any reasonable time any such accounts and records directly pertaining to his or her interest, and the Plan Administrator shall provide such reports and statements to each Participant or his or her beneficiary as it shall deem appropriate.

Section 7.3 Compensation for Services. The Plan Administrator shall not be entitled to compensation for its services as such. All fees, salaries, and other costs of providing services to the Program shall be paid by the Employer or with forfeitures, if any, as provided in Section 4.8 unless the Plan Administrator, in its sole discretion, determines that such expenses should be paid from Contributions.
Section 7.4  Duties of Plan Administrator. The Plan Administrator shall have such duties and powers as may be necessary to discharge its duties hereunder, including, but not by way of limitation, the right and authority:

(a) in its sole and exclusive discretion, to interpret the terms and provisions of the Program and to resolve all questions arising thereunder, including, without limitation, the authority to determine eligibility for benefits and the amount, manner and time of payment of such benefits, the right to make factual determinations, and the right to resolve and remedy ambiguities, inconsistencies or omissions in the Program. This authority shall include the right to make a determination as to whether or not a particular limitation, exclusion or other restriction under the Program is applicable in a particular situation, including, without limitation, the right to determine whether or not an individual's condition is physical or mental in nature;

(b) to prescribe procedures to be followed by Participants filing applications for benefits;

(c) to direct the Insurer as to the payment of benefits hereunder;

(d) to prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, information explaining the Program;

(e) to receive from Participants such information as shall be necessary for the proper administration of the Program;

(f) to prepare such annual reports with respect to the administration of the Program as are reasonable and appropriate; and

(g) to appoint individuals to assist in the administration of the Program and any other agents it deems advisable, including legal counsel.

Section 7.5  Rules. The Plan Administrator may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Plan Administrator shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished by a Participant or the legal counsel of the Employer.

Section 7.6  Bylaws and Regulations. The Plan Administrator may adopt such bylaws and regulations as it deems desirable for the conduct of its affairs.

Section 7.7  Documentation by Participant. The Plan Administrator may require a Participant to complete and file with the Plan Administrator an application for a benefit and all other forms approved by the Plan Administrator, and to furnish all pertinent information requested by the Plan Administrator. The Plan Administrator may rely upon all such information so furnished it.

Section 7.8  Incapacity. Whenever, in the Plan Administrator's opinion, a person entitled to receive any payment of a benefit or installment thereof hereunder is under a legal disability or is incapacitated in any way so as to be unable to manage the person's financial
affairs, the Plan Administrator may direct the Insurer to make payments to such person or to the
person's legal representative or to a relative or friend of such person for such person's benefit, or
the Plan Administrator may direct the Insurer to apply the payment for the benefit of such person
in such manner as the Plan Administrator considers advisable. Any payment of a benefit or
installment thereof in accordance with the provisions of this Section shall be a complete
discharge of any liability for the making of such payment under the provisions of the Program.

Section 7.9 Liabilities. To the extent permitted by law, neither the Plan Administrator,
nor any director, officer or employee of the Employer or a Participating Employer shall be liable
for any action or failure to act under or in connection with the Program, except for his or her own
gross misconduct or bad faith. Each person who is or shall have been a Plan Administrator or a
director, officer or employee of the Employer or a Participating Employer shall be indemnified
and held harmless by the University against and from any and all loss, cost, liability or expense
that may be imposed upon or reasonably incurred by him or her in connection with or resulting
from any claim, action, suit or proceeding to which he or she may be party or in which he or she
may be involved by reason of any action taken or failure to act under the Program and against
and from any and all amounts paid by him or her in settlement thereof (with the University's
written approval) or paid in satisfaction of a judgment in any such action, suit or proceeding,
except a judgment based upon a finding of bad faith; subject, however, to the condition that,
upon the assertion or institution of any such claim, action, suit or proceeding against him or her,
he or she shall in writing give the University an opportunity, at its own expense, to handle and
defend the same before he or she undertakes to handle and defend it on his or her own behalf.
The foregoing right of indemnification shall not be exclusive of any other right to which such
person may be entitled as a matter of law or otherwise, or any power that an Employer may have
to indemnify him or her or to hold him or her harmless.

Section 7.10 Named Fiduciaries. The Plan Administrator shall be the "named
fiduciary" (within the meaning of section 402(a)(2) of ERISA) with the authority to control and
manage the operation and administration of the Program. The named fiduciary may allocate or
delegate fiduciary responsibilities to other persons (including, but not limited to, an Insurer or
Claims Administrator). Such allocation or delegation shall be made by designating in writing the
fiduciary to whom the responsibility is allocated or delegated and shall contain a brief
description of the responsibilities so delegated.
ARTICLE VIII

AMENDMENT AND TERMINATION

Section 8.1 Amendment. The Vice President for Human Resources shall have the right to amend the Program from time to time. No amendment of this Program shall deprive any Participant or beneficiary of any benefit to which the Participant or beneficiary is entitled under this Program with respect to contributions previously made, and no amendment shall provide for the use of funds or assets other than for the benefit of Eligible Employees and their beneficiaries, except as may be specifically authorized by statute or regulation. The Plan Administrator shall promptly notify the Insurer and Participating Employers of any amendments to this Program.

Section 8.2 Termination. The Vice President for Human Resources shall have the right to terminate the Program at any time and each Participating Employer reserves the right to terminate the Program with respect to its Employees, by resolution of its board of directors or other authorized representative and written notice to the Plan Administrator and the Insurer. Any termination of the Program shall not adversely affect the payment of benefits to which Participants or their covered dependents were entitled under the terms of the Plan prior to the date of termination.

Section 8.3 Continuation of Program. Upon the termination of the Program, the Program shall be continued, as directed by the Plan Administrator in order to pay benefits until Contributions are exhausted. Except to the extent provided herein, no Contributions shall revert to, or inure to the benefit of, the Employer.
ARTICLE IX

MISCELLANEOUS

Section 9.1 Program Not an Employment Contract. The Program shall not be deemed to constitute an employment contract between the University or a Participating Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Program shall be deemed to give any Participant or Employee the right to be retained in the service of the University or Participating Employer or to interfere with the right of the University or Participating Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge will have upon him or her as a Participant of this Program.

Section 9.2 No Other Benefits. Except as provided in Section 4.8, no part of the Contributions to the Program shall be used for, or diverted to, purposes other than the exclusive benefit of the Participants and their beneficiaries and for defraying reasonable expenses of administering the Program to the extent not otherwise paid by the Employer. No person shall have any interest in or right to any part of the earnings on Contributions to the Program, except as and to the extent expressly provided in the Plans or the Contracts. All payments of benefits as provided for in this Program shall be made solely from Contributions as direct payments from the Employer or Insurer to the Participant or to a third-party provider under Section 6.1, and the Plan Administrator shall not be liable therefor in any manner.

Section 9.3 Assignment of Benefits. Except as may be permitted under any Contract under the Group Life Insurance Plan, benefits payable under the Program shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a Spouse or former Spouse, or for any other relative of the Employee, prior to actually being received by the person entitled to the benefit under the terms of the Program; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable hereunder, shall be void. The Employer shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder. The payment of benefits directly to a health care provider under Section 6.1, if any, shall be done as a convenience to the Participant and shall not constitute an assignment of benefits under the Plan.

Section 9.4 Status of Benefits. The University believes that this Program is in compliance with section 125 of the Code and that it provides certain benefits to Employees which are tax free pursuant to other provisions of the Code. This Program has not been submitted to the Internal Revenue Service for approval and thus there can be and there is no assurance that intended tax benefits will be available. Any Participant, by accepting a benefit under this Program, agrees to be liable for any tax that may be imposed with respect to those benefits, plus interest as may be imposed.

Section 9.5 Lost Distributees. Any benefit payable hereunder shall be deemed forfeited if the University is unable to locate the Participant to whom payment is due; provided,
however, that such benefit shall be reinstated if a claim is made by the Participant for the forfeited benefit within two years of the date the claim is incurred, unless the applicable contract provides otherwise.

Section 9.6 Severability. If any provision of this Program shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Program shall be construed and enforced as if such provision had not been included.

Section 9.7 Binding on Successors. This Program shall be binding upon and inure to the benefit of the Employer, its successors and assigns and the Participant and his or her heirs, executors, administrators and legal representatives.

Section 9.8 Heirs and Assigns. This Program shall be binding upon the heirs, executors, administrators, successors and assigns of all parties, including each Participant and beneficiary.

Section 9.9 Controlling Laws. The law of the Commonwealth of Pennsylvania, without regard to its choice of law principles, shall be the controlling state law in all matters relating to the construction and administration of the Plan and shall apply to the extent it is not preempted by ERISA or other applicable federal law. The courts of competent jurisdiction in Philadelphia, Pennsylvania, shall have exclusive jurisdiction for all claims, actions and other proceedings involving or relating to the Plan, including, by way of example and without limitation, a claim or action (a) to recover benefits allegedly due under the Plan or by reason of any law; (b) to enforce rights under the Plan; (c) to clarify rights to future benefits under the Plan; or (d) that seeks a remedy, ruling or judgment of any kind against the Plan or any Plan fiduciary or other party.

Section 9.10 Heads and Captions. The heading and captions set forth in the Program are provided for convenience only and shall not be considered part of the Program, and shall not be employed in the construction of the Program.

Section 9.11 Special Rules Related to the COVID-19 Pandemic. Certain changes to the Plan's provisions as described in this Section 9.11 shall be made in response to the ongoing National Health Emergency (the "Emergency") stemming from the COVID-19 Pandemic (the "Pandemic"). In general, these changes are intended to be temporary in nature and to apply only during the Emergency. Once the Emergency ends, except as otherwise provided below, these special provisions shall be of no further force and effect and the normal Plan terms shall apply, except as provided below.

(a) COVID-19 Testing. Effective March 18, 2020, all medical plan options under the Plan shall provide certain items and services as required under the Families First Coronavirus Response Act (the "FFCRA") and the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"). Specifically, such plans shall provide coverage, and shall not impose any cost sharing (including deductibles, copayments, and coinsurance) requirements or prior authorization or other medical management requirements, for the following items and services furnished during the coronavirus disease pandemic, regardless of whether the items or services are so furnished by an in-network or out-of-network health care provider:
(1) a test for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 that is (i) approved, cleared, or authorized under the Federal Food, Drug, and Cosmetic Act, (ii) allowed pursuant to an emergency use authorization under section 564 of the Federal Food, Drug and Cosmetic Act, (iii) being developed and used in States who have notified HHS, and (iv) any other test allowed by Secretary of HHS, and the administration of any such test;

(2) items and services furnished to an individual during a health care provider visit (including an in-person visit and a telemedicine visit), urgent care center visit, or emergency room visit that results in an order for or administration of a test described in the bullet above, but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such test; and

(3) the cost of items and services furnished during a health care office visit (whether in person or via telemedicine), urgent care visit or emergency room visit that results in the administration of, or order for, a COVID-19 test, but only to the extent such items or services relate to the administration of a COVID-19 test or the evaluation of whether a test is needed. These services will not be subject to any prior authorization or other medical management requirements. To the extent these services are rendered by an in-network provider, the Plan will cover the cost at 100%, meaning the individual will not be required to pay any deductible, co-payment or co-insurance. To the extent such services are rendered by an out-of-network provider, the Plan will pay the maximum amount required by law and the individual may be required to pay the difference.

(b) COVID-19 Vaccinations. Effective March 27, 2020, all medical plan options under the Plan shall provide "qualifying coronavirus preventive services" without cost sharing (including deductibles, copayments, and coinsurance) as required under the CARES Act. For this purpose, "qualifying coronavirus preventive services" shall mean an item, service, or immunization that is intended to prevent or mitigate COVID-19 and that is—

(1) an evidence-based item or service that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; or

(2) an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
Any such qualifying coronavirus preventive service shall be provided as of the date that is 15 business days after the date on which a recommendation is made by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention relating to the qualifying coronavirus preventive service.

(c) Extension of Deadlines. In accordance with Internal Revenue Service ("IRS") and Department of Labor ("DOL") guidance, the period of time known as the "Outbreak Period" must be disregarded when determining whether certain actions under the Plan are timely. The Outbreak Period runs from March 1, 2020, until the date that is 60 days after the announcement of the end of the Emergency, or such other date announced by the IRS and DOL. Accordingly, effective March 1, 2020, the Outbreak Period will be disregarded for purposes of determining the following deadlines:

1. The time period an employee has to enroll in the Plan after they have a special enrollment event (i.e., 30 days or 60 days after the event, depending on the event);

2. The time period an employee has to notify the Plan of a qualifying event that would make him or her (or a family member) eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), such as a divorce, separation or a child ceasing to meet the Plan's eligibility requirements (i.e., 60 days after the qualifying event);

3. The time period for the Plan to send a COBRA election notice once it learns of a qualifying event that a qualified beneficiary or the Employer reports (such as a termination for reasons other than gross misconduct, reduction in hours, or layoff, divorce, etc.) (i.e., 30 days);

4. The time period to notify the Plan of a disability determination from the Social Security Administration in order to extend the COBRA period from 18 to 29 months (60 days after the determination);

5. The time period to elect to COBRA continuation coverage (i.e., 60 days after receiving the COBRA election notice);

6. The time period to pay premiums after COBRA continuation coverage is elected (45 days for the initial premium, by the first of the month for each month of coverage thereafter subject to a 30-day grace period);

7. The time period to file a benefit claim; and

8. The time period to appeal the denial of a benefit claim (i.e., 180 days after a denied health care claim or 60 days after any other denied claim).
(d) **Special Rules Related to the Health Care Pre-Tax Expense Account Plan.** The following special rules shall apply to the Health Care Pre-Tax Expense Account Plan effective May 1, 2020:

1. The date for incurring health care claims for the Plan Year ended June 30, 2020 is extended to December 31, 2020. The date for submitting claims for this extended period is March 1, 2021.

2. Notwithstanding the $550 limit on carryovers described in Section 5(b) of Appendix E, any unused amounts remaining in a Participants Health Care Pre-Tax Spending Account at the end of the Plan Year ending June 30, 2020 and the Plan Year ending June 30, 2021 can be used to reimburse Health Care Expenses that are incurred during the immediately following Plan Year.

3. Participants may change the anticipated amount of Contributions to be allocated to this Plan on his or her behalf without declaring a specific life event in accordance with procedures established by the Plan Administrator. This change may be made for the remaining pay periods in the Plan Year ending June 30, 2020 and any time during the period July 1, 2020 through December 31, 2020. Contributions deducted prior to the change will be subject to the otherwise applicable reimbursement rules and will not be refunded.

(e) **Special Rules Related to the Dependent Care Pre-Tax Expense Account Plan.** The following special rules shall apply to the Dependent Care Pre-Tax Expense Account Plan effective May 1, 2020:

1. The date for incurring dependent care claims for the Plan Year ended June 30, 2020 is extended to December 31, 2020. The date for submitting claims for this extended period is March 1, 2021.

2. Any unused amounts remaining in a Participants Dependent Care Pre-Tax Spending Account at the end of the Plan Year ending June 30, 2020 and the Plan Year ending June 30, 2021 can be used to reimburse Dependent Care Expenses that are incurred during the immediately following Plan Year.

3. Participants may change the anticipated amount of Contributions to be allocated to this Plan on his or her behalf without declaring a specific life event in accordance with procedures established by the Plan Administrator. This change may be made for the remaining pay periods in the Plan Year ending June 30, 2020 and any time during the period July 1, 2020 through December 31, 2020. Contributions deducted prior to the change will be subject to the otherwise applicable reimbursement rules and will not be refunded.
ARTICLE X

HIPAA PRIVACY & PROTECTED HEALTH INFORMATION

Section 10.1 Purpose. This Article permits the Plan to disclose protected health information ("PHI"), as defined in HIPAA, to the Employer to the extent that such PHI is necessary for the Employer to carry out its administrative functions related to the Plan. This amendment reflects the requirements set forth in 45 C.F.R. §164.504(f) of HIPAA and the related regulations promulgated by HHS.

Section 10.2 Disclosure To The Employer. The Plan (or health insurance issuer or HMO with the Plan's permission) may disclose the PHI to the Employer that is necessary for the Employer to carry out the following administrative functions related to the Plan: eligibility determinations, enrollment and disenrollment activities, and Plan amendments or termination. The Employer may use and disclose the PHI provided to it from the Plan (or health insurance issuer or HMO) only for the administrative purposes described in this paragraph.

Section 10.3 Limitations And Requirements Related To The Use and Disclosure of PHI. The Employer agrees to the following limitations and requirements related to its use and disclosure of PHI received from the Plan:

(a) Use and Further Disclosure. The Employer shall not use or further disclose PHI other than as permitted or required by the Plan document or as required by all applicable law, including but not limited to HIPAA. When using or disclosing PHI or when requesting PHI from the Plan, the Employer shall make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.

(b) Agents and Subcontractors. The Employer shall require any agents, including subcontractors, to whom it provides PHI received from the Plan to agree to the same restrictions and conditions that apply to the Employer with respect to such information.

(c) Employment-Related Actions and Decisions. Except as permitted by HIPAA and other applicable federal and state privacy laws, the Employer shall not use PHI for employment-related actions and decisions, or in connection with any other employee benefit plan of the Employer.

(d) Reporting of Improper Use or Disclosure. The Employer shall promptly report to the Plan any improper use or disclosure of PHI of which it becomes aware.

(e) Adequate Protection. The Employer shall provide adequate protection of PHI and separation between the Plan and the Employer by:

(1) ensuring that only those employees who work in the human resources department of the Employer on issues related to the healthcare components of the Plan will have access to the PHI provided by the Plan;
(2) restricting access to and use of PHI to only the employees identified in paragraph (1) above and only for the administrative functions performed by the Employer on behalf of the Plan that are described in Section 10.2 above;

(3) requiring any agents of the Plan who receive PHI to abide by the Plan's privacy rules; and

(4) using the Employer's established disciplinary procedures to resolve issues of noncompliance by the employees identified in paragraph (1) above.

(f) **Return or Destruction of PHI.** If feasible, the Employer shall return or destroy all PHI received from the Plan that the Employer maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the Employer shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(g) **Participant Rights.** The Employer shall provide Participants with the following rights:

(1) the right to access to their PHI in accordance with 45 C.F.R. §164.524;

(2) the right to amend their PHI upon request (or the Employer will explain to the Participant in writing why the requested amendment was denied) and incorporate any such amendment into a Participant's PHI in accordance with 45 C.F.R. §164.526; and

(3) the right to an accounting of all disclosures of their PHI in accordance with 45 C.F.R. §164.528.

(h) **Cooperation with HHS.** The Employer shall make its books, records, and internal practices relating to the use and disclosure of PHI received from the Plan available to HHS for verification of the Plan's compliance with HIPAA.

Section 10.4 **Certification.** The Plan will disclose PHI to the Employer only upon receipt of Certification by the Employer that the Plan documents have been amended in accordance with 45 C.F.R. §164.504(f), and that the Employer shall protect the PHI as described in Paragraph 3 herein.

Section 10.5 **Security Standards Requirement.** To comply with the Security Standards regulations that were published on February 21, 2003, the Company must:

(a) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
(b) ensure that the adequate separation required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(c) ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

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

Section 10.6 Amendment. Notwithstanding any other provision of the Plan, this Article XII may be amended in any way and at any time by the Privacy Officer.

Section 10.7 Effective Dates. Sections 10.1 – 10.4 and Section 10.6 apply to the Plan no later than April 14, 2003, or such other date that the HIPAA Privacy Regulations apply to the Plan. Section 10.5 applies to the Plan no later than April 20, 2005, or such other date that the HIPAA Security Regulations apply to the Plan.

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IN WITNESS WHEREOF, the Vice President for Human Resources, acting on behalf of the University, has caused this amendment and restatement of the University of Pennsylvania Health and Welfare Program to be executed in its name and behalf this _________ day of ______________________, 2021.

THE TRUSTEES OF THE
UNIVERSITY OF PENNSYLVANIA

By: ____________________________

Title: ____________________________
APPENDIX A

MEDICAL PLAN

Section 1. Eligibility. Each Participant shall be eligible to elect any one of the benefits described in the applicable Contracts, except to the extent otherwise specified by the University, in its sole discretion.

Section 2. Options and Coverage. Each Participant shall elect a coverage option category and a coverage level as described in the enrollment materials provided by the Employer. The Participant may also elect to waive coverage under the Plan as provided on the benefit election form. Prior to the date the Participant commences coverage or in the event that a Participant fails to make a valid election during the Election Period or Reelection Period, the following rules shall apply:

(a) Prior to the date the Participant’s coverage commences or if such individual had not followed the enrollment procedure established by the Plan Administrator with respect to this Plan for a previous Plan Year, he or she shall be deemed to have waived coverage under this Plan.

(b) If such individual had followed the enrollment procedure established by the Plan Administrator with respect to this Plan for a previous Plan Year, he or she shall be deemed to have elected the same coverage (including no coverage, if applicable) under this Plan as specified in his or her most recent election.

Section 3. Funding. Benefits shall be funded in accordance with the applicable Contract, the terms of which are incorporated herein by reference. The costs of such benefits shall be paid by the Employer and by the Participant in accordance with this Plan and according to the allocations made by the Participant under the Program, and in such amounts as are determined annually by the University prior to the Election or Reelection Period.

Section 4. Benefits. Medical benefits shall include the reasonable and customary fee or other negotiated fee for prescription drugs, medical, hospital and surgical expenses incurred for a covered injury or sickness for Participants and, if coverage is so elected, for eligible Dependents in accordance with the terms of the applicable Contract.

Section 5. Compliance with Certain Requirements of PPACA. The Plan will comply with the applicable requirements of the Patient Protection and Affordable Care Act of 2010 and the guidance issued in connection therewith, including the following:

(a) No Lifetime or Annual Limits. The Plan shall not impose a lifetime or annual limit on the dollar value of essential health benefits provided under the Plan.

(b) No Rescission of Coverage. The Plan shall not cancel or discontinue benefits under the Plan with a retroactive effect with respect to a Participant or covered Dependents except in the event of fraud or intentional misrepresentation or otherwise permitted under regulations.
APPENDIX B

DENTAL PLAN

Section 1. Eligibility. Consistent with the provisions of Section 1.12, each Participant shall be eligible to elect the benefits described in the applicable Contract except to the extent otherwise specified by the University, in its sole discretion.

Section 2. Options and Coverage. Each Participant shall elect a coverage option category and a coverage level as described in the enrollment materials provided by the Employer. The Participant may also elect to waive coverage under the Plan as provided on the benefit election form. Prior to the date the Participant commences coverage or in the event that a Participant fails to make a valid election during the Election Period or Reelection Period, the following rules shall apply:

(a) Prior to the date a Participant's coverage commences or if such individual had not followed the enrollment procedure established by the Plan Administrator with respect to this Plan for a previous Plan Year, he or she shall be deemed to have waived coverage.

(b) If such individual had followed the enrollment procedure established by the Plan Administrator with respect to this Plan for a previous Plan Year, he or she shall be deemed to have elected the same coverage (including no coverage, if applicable) under this Plan as specified in his or her most recent election.

Section 3. Funding. Benefits shall be funded in accordance with the applicable Contract, the terms of which are incorporated herein by reference. The costs of such benefits shall be paid by the Employer and by the Participant in accordance with this Plan and according to the allocations made by the Participant under the Program, and in such amounts as are determined annually by the University prior to the Election Period or Reelection Period.

Section 4. Benefits. Dental benefits shall include the reasonable and customary fees or other negotiated fee charged by a dentist, orthodontist, or other professional providing dental services for Participants and, if coverage is so elected, for eligible Dependents, in accordance with the terms of the applicable Contract.
APPENDIX C

GROUP LIFE INSURANCE PLAN

Section 1. Eligibility. Subject to Sections 1.12 and Article II, Each Participant shall be eligible to elect a level of life insurance described in the applicable Contract, except to the extent otherwise specified by the University, in its sole discretion.

Section 2. Options. Subject to the eligibility provisions of Section 1 above, each Participant shall elect a coverage option category as described in the enrollment materials provided by the Employer. Prior to the date coverage commences or in the event that a Participant fails to make a valid election during the Election Period or Reelection Period, the following rules shall apply:

(a) Prior to the date the Participant's coverage commences or if such individual had not followed the enrollment procedure established by the Plan Administrator form with respect to this Plan for a previous Plan Year, he or she shall receive basic group life insurance and AD&D coverage under the applicable Contract, if eligible.

(b) If such individual had followed the enrollment procedure established by the Plan Administrator with respect to this Plan for a previous Plan Year, he or she shall be deemed to have elected the same coverage under this Plan as specified in his or her most recent election.

Section 3. Funding. Benefits shall be funded in accordance with the applicable Contract, the terms of which are incorporated herein by reference. The costs of such benefits shall be paid by the Employer and by the Participant in accordance with this Plan and according to the allocations made by the Participant under the Program, and in such amounts as are determined annually by the University prior to the Election Period or Reelection Period.

Section 4. Benefits. Benefits shall be various forms of life insurance in the event of the Participant's death or Dependent's death, in accordance with the Participant's election and the terms of the applicable Contract.

Section 5. Minimum Level of Death Benefits. In no event shall a Participant be permitted to make an election that would result in a death benefit payable on the death of the Participant that is less than the lesser of (1) $50,000 or (2) the Participant's "annual benefits base." For purposes of this Section 5, "annual benefits base" is the Participant's annual eligible earnings as of a date specified by the Employer each Plan Year, or for an Employee who first becomes eligible to become a Participant on a date other than the first day of the Plan Year, as of the date such Employee becomes an Eligible Employee.
APPENDIX D

DEPENDENT LIFE INSURANCE PLAN

Section 1. Eligibility. Subject to the provisions of Section 1.12, each Participant shall be eligible to elect a level of life insurance described in the applicable Contract, except to the extent otherwise specified by the University, in its sole discretion.

Section 2. Options. Subject to the eligibility provisions of Section 1 above, each Participant shall elect a coverage option category as described in the enrollment materials provided by the Employer. Prior to the date coverage commences or in the event that a Participant fails to make a valid election during the Election Period or Reelection Period, the following rules shall apply:

(c) Prior to the date the Participant's coverage commences or if such individual had not followed the enrollment procedure established by the Plan Administrator with respect to this Plan for a previous Plan Year, he or she shall be deemed to have waived coverage.

(d) If such individual had followed the enrollment procedure established by the Plan Administrator with respect to this Plan for a previous Plan Year, he or she shall be deemed to have elected the same coverage under this Plan as specified in his or her most recent election.

Section 3. Benefits. Benefits shall be life insurance in the event of the covered Dependent's death, in accordance with the terms of the applicable Contract.

Section 4. Funding. Benefits shall be funded in accordance with the applicable Contract, the terms of which are incorporated herein by reference. The costs of such benefits shall be paid by the Employer and by the Participant in accordance with this Plan and according to the allocations made by the Participant under the Program, and in such amounts as are determined annually by the University prior to the Election Period or Reelection Period.
APPENDIX E

HEALTH CARE PRE-TAX EXPENSE ACCOUNT PLAN

Section 1. Definitions. For purposes of this Appendix E, the following terms shall have the meanings set forth below:

"Dependent" shall mean the Participant's Spouse and any individual who is a dependent of the Participant within the meaning of section 152 of the Code, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof. Any child to whom section 152(e) of the Code (regarding divorced or separated parents) applies shall be treated as a dependent of both parents for purposes of this definition.

"Health Care Expenses" shall mean expenses incurred by a Participant or his or her Dependent for "medical care" as defined in section 213(d) of the Code (including, without limitation, amounts paid for hospital, doctor and dental bills), but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through insurance or from any other source (other than under this Plan), including reimbursement from another plan maintained by the Employer. Health Care Expenses shall not include (a) premiums for other health plan coverage, including premiums paid for health plan coverage under a plan maintained by the employer of the Participant's Spouse or Dependents or premiums paid for individual health coverage, (b) cost containment penalties under the Medical Plan or the Dental Plan, or (c) expenses claimed as a deduction on the federal income tax return of the Participant or his or her Spouse or Dependent. Notwithstanding the foregoing, Health Care Expenses shall include (a) expenditures for over the counter medicines or drugs (whether or not prescribed by a physician) and (b) menstrual care products.

Section 2. Eligibility. Subject to the provisions of Section 1.12, a Participant who incurs Health Care Expenses during the Plan Year shall be entitled to elect benefits under this Plan, which incorporates the requirements of section 105(b) of the Code relating to medical reimbursement plans. Such Participant shall receive reimbursement from his or her Health Care Expense Account for those expenses incurred during the Plan Year or during the part of the Plan Year in which the Participant had in effect an election to participate in this Plan.

Section 3. Coverage. A Participant may elect benefits of no more than $2,750 per Plan Year, or such other adjusted amount under section 125(i)(2) of the Code. Any change in the maximum contribution amount shall be effective as of the first day of the Plan Year that begins within the calendar year for which the adjustment applies. At all times during the Plan Year, a Participant or COBRA Participant shall be entitled to reimbursement in an amount that does not exceed the anticipated amount of Contributions to be allocated to this Plan on his or her behalf (less any amounts previously reimbursed), regardless of the actual amount then standing to his or her credit under the Plan. Each payment hereunder shall be a charge to such amount available to pay covered expenses under the Plan.

A Participant failing to follow the enrollment procedure established by the Plan Administrator during any initial Election Period, or any Participant failing to specify an amount of coverage, shall be deemed to have elected no coverage. A Participant failing to follow the
enrollment procedure established by the Plan Administrator during any Reelection Period shall be deemed to have elected the same level of coverage as chosen in his or her most recent election.

Section 4. **Funding.** Benefits shall be funded by Contributions, as elected by the Participant, and shall be paid from the general assets of the Employer.

Section 5. **Filing of Claim.**

(a) **In General.** In order to receive reimbursement, the Participant (or his or her beneficiary, in the event of the Participant's death) shall file a claim or claims with the Plan Administrator on a form provided for such purpose. Claims shall be accompanied by original bills or other proof of services. Expenses shall be deemed incurred in the Plan Year in which medical services are provided. The amount that may be submitted as a claim shall not be less than the minimum reimbursement amount established by the University. The claim(s) must be filed no later than September 30 following the Plan Year during which the expense was incurred. Upon approval of a claim by the Plan Administrator, the Participant shall be entitled to reimbursement, but in no event shall the total dollar amount of approved claims for any Plan Year exceed the total amount allocated to the Participant's Health Care Expense Account for the Plan Year. Subject to the Special Carryover Option described in Section 5(b), any unclaimed balance remaining in the Participant's Health Care Expense Account for any Plan Year, attributable to Contributions made during such Plan Year, shall be forfeited and applied as provided in Section 4.8 of the Program. A Participant who has terminated service with the Employer and who has not elected continuation coverage under Article III with respect to this Plan shall be entitled to continue to make claims for Health Care Expenses incurred prior to such termination.

(b) **Special Carryover Option.** Unused amounts of up to $550 remaining in a Participant's Health Care Pre-Tax Spending Account at the end of any Plan Year can be used to reimburse Health Care Expenses that are incurred during the following Plan Year. The following requirements will apply to the Health Care Pre-Tax Spending Account carryover:

1. The amount that can be carried over is equal to the lesser of 1) any unused amounts from the prior Plan Year after the end of the prior Plan Year's run-out period; or 2) $550. The run-out period is the period ending on September 30 after the end of the Plan Year during which the Participant can submit Health Care Expenses incurred in the prior Plan Year for reimbursement.

2. Carryovers may not be cashed out or converted to any other taxable or nontaxable benefit, and will not count towards the maximum dollar limit under the Health Care Pre-Tax Spending Account Plan.

3. Health Care Expenses that are incurred in the current Plan Year will be reimbursed first from a Participant's unused Health Care Pre-Tax Spending Account amounts credited for that Plan Year.
and then from amounts carried over from the preceding Plan Year. Carryovers that are used to reimburse a Health Care Expense in a current Plan Year will reduce the amount available to pay Health Care Expenses incurred in the prior Plan Year during the run-out period, cannot exceed $550, and will count against the $550 maximum carryover amount. The carryover is available even if a Health Care Pre-Tax Spending Account election is not made for a subsequent plan year.

(4) Any balance in excess of $550 shall not be carried over to reimburse Health Care Expenses incurred during a subsequent Plan Year and shall not be available to the Participant in any other form or manner. Any unused amounts exceeding $550 shall be forfeited and applied as provided in Section 4.8 of the Program.

(c) Withdrawals During a Military Leave of Absence. Notwithstanding any provision of this Section 5 to the contrary, a Participant who is on an approved Military Leave of Absence (as defined below) for a period of more than 179 days (or for an indefinite period of time) may be entitled to a distribution of some or all of the remaining amounts attributable to his or her ledger account which otherwise may be forfeited in accordance with this Section 5. The following rules apply:

(1) A Participant is on an approved "Military Leave of Absence" if he or she is in the Armed Forces, such as the Army, Navy, Air Force, Marines, Coast Guard, the Army and Air National Guards or the corps of the Public Health Service, is covered under USERRA and complies with the notice requirements under the Employer's military leave of absences policies.

(2) A distribution may be requested even if the Participant has not incurred a Health Care Expense during the Plan Year. Amounts received under this special rule will not be available to reimburse the Participant for Health Care Expenses incurred during the Plan Year.

(3) Any amounts distributed in accordance this special rule and which are not reimbursements for Health Care Expenses, will be treated as taxable income paid to the Participant and will be subject to income tax withholding.

(4) A request for a distribution under this special rule must be in writing and received by the Plan Administrator before September 30 of the Plan Year following the Plan Year in which the Military Leave of Absence commenced. The Participant may be required to submit proof of the duration of your approved Military Leave of Absence and comply with any administrative procedures adopted by the Plan Administrator.
Section 6. **Documentation Required.** Prior to making any payment of benefits under the Plan, the Plan Administrator may require the Participant to provide such evidence of Health Care Expenses as is sufficient to enable the Plan Administrator to determine that the Health Care Expenses qualify for reimbursement and to make an accurate determination of the amount of benefit to be paid. Such evidence shall consist of information from an independent third party that describes the service or product, the date of the sale or service, and the amount. Self-substantiation of the expense by the Participant is not sufficient. Acceptable forms of substantiation also include an explanation of benefits from an insurance company or third-party administrator.

Section 7. **Certification of Validity.** An Employee submitting a claim for reimbursement of an expense shall certify, on the form on which such claim is made, that the expense is a Health Care Expense within the meaning of Section 1 above. The Employer and the Plan Administrator shall be entitled to rely on such certification for all purposes.

Section 8. **Special Rule for COBRA Continuation Coverage.** Notwithstanding any other provision of the Program to the contrary, for the Plan Year in which a Qualifying Event occurs, the amount to be applied for the benefit of the Qualified Beneficiary for payment of Health Care Expenses shall be the amount so allocated for the Plan Year by the Participant, except that payments to a Participant under this Plan prior to the Qualifying Event shall be charged to the amount available to pay Health Care Expenses for such Plan Year with respect to both the Participant (or Qualified Beneficiary, if the Qualified Beneficiary ceases to be a Participant by reason of the Qualifying Event) and any Qualified Beneficiary whose right to continue to participate in this Plan derives from a relationship to such Participant.

Section 9. **Treatment of Employees Who Terminate or Otherwise Change Status.** In the case of Employees whose employment with the Employer is terminated during a Plan Year, or who otherwise cease to be Eligible Employees, or who have made an effective election under Section 5.2 of the Program to cease participation herein on a date other than the last day of a Plan Year, accruals of Contributions shall cease as of the effective date of such change, but reimbursements with respect to prior accruals shall continue to be made through the September 30 of the following Plan Year for covered expenses incurred through the date of termination or change in status.

Section 10. **Consequences of Reimbursement of Noncovered Expenses.** In the event of a determination by the Plan Administrator, or by an appropriate governmental body, that reimbursements under this Plan are taxable to an Employee, such Employee shall pay:

(a) any state or federal income taxes due with respect to such amounts, together with any interest or penalties imposed thereon,

(b) the Employee's share (as determined in good faith by the Employer) of any FICA, FUTA, or state employee benefit contributions, which would have been withheld by the Employer had such amounts been paid as taxable cash compensation, and
(c) an amount (as determined in good faith by the Employer) equal to the portion allocable to the Employee of any penalties and interest payable by the Employer as a result of the failure to withhold and pay such amounts to the appropriate payee.
APPENDIX F

DEPENDENT CARE PRE-TAX EXPENSE ACCOUNT PLAN

Section 1. Definitions. For purposes of this Appendix F, the following terms shall have the meanings set forth below:

"Dependent Care Center" shall mean any facility which provides care for more than six individuals (other than individuals who reside at the facility), which receives a fee, payment or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit) and which complies with all applicable laws and regulations of a state or unit of local government.

"Dependent Care Expenses" shall mean amounts which qualify as employment related expenses pursuant to the requirements of section 21 of the Code but for which a Participant does not claim a dependent care credit under such section and which are paid for household services and care of a Qualifying Individual if such amounts are to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Individuals with respect to the Participant; provided, however, that expenses which are incurred for services outside the Participant's household shall be taken into account only if incurred for the care of a dependent of the Participant who is under the age of 13 or any other Qualifying Individual who regularly spends at least eight hours each day in the Participant's household; and provided, further, that services provided by a Dependent Care Center shall be taken into account only if the Center complies with all applicable laws and regulations of a state or unit of local government. Dependent Care Expenses shall not include amounts paid or incurred to an individual with respect to whom the Participant or his or her Spouse is entitled to a deduction under section 151(c) of the Code (relating to a deduction for personal exemption for dependents) or who is a child of such Participant (within the meaning of section 152(f)(1) of the Code) who has not attained the age of 19 at the close of the year.

"Earned Income" shall mean an individual's wages, salary, tips and other employee compensation, plus the amount of the individual's net earnings from self-employment for the taxable year, but shall not include pensions or annuities, amounts to which section 871(a) of the Code applies (relating to income of a nonresident alien individual not connected with a United States business) or amounts paid or incurred by an individual's employer for dependent care assistance to an employee; provided, however, that in the case of a Participant's Spouse who is a student or physically or mentally incapable of self-care, such Spouse shall be deemed for each month during which such Spouse is a full-time student at an educational institution, or is incapable of self-care, to be gainfully employed and to have earned income of not less than (a) $250, if there is one Qualifying Individual with respect to the Participant for the taxable year or (b) $500, if there are two or more Qualifying Individuals for the taxable year.

"Qualifying Individual" shall mean (a) a dependent of the Participant (within the meaning of section 152(a)(1) of the Code) who is under the age of 13, (b) a dependent of the Participant (within the meaning of section 152 of the Code) who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than one-half of
the year, or (c) the Spouse of the Participant, if he or she is physically or mentally incapable of self-care and has the same principal place of abode as the Participant for more than one-half of the year. Notwithstanding the foregoing, if:

(1) either section 152(e) of the Code (regarding divorced or separated parents) is applicable to a child of an Employee, and

(2) such child is under the age of 13 or is physically or mentally incapable of self-care,

then such child shall be deemed a Qualifying Individual (described in subsection (a) or (b) above) with respect to the Participant if such Participant is the custodial parent of the child within the meaning of section 152(e)(3)(A) of the Code.

Section 2. Eligibility. Subject to Section 1.12, a Participant who incurs Dependent Care Expenses during the Plan Year shall be entitled to elect benefits under this Plan, which incorporates the requirements of section 129 of the Code relating to dependent care assistance programs. Such Participant shall receive reimbursement from his or her Dependent Care Expense Account for those expenses that were incurred during the Plan Year or during the part of the Plan Year in which the Participant had in effect an election to participate in this Plan.

Section 3. Coverage. A Participant may elect benefits of no more than $5,000 for a calendar year. Notwithstanding the foregoing, the Plan Administrator may require the Participant to state (and the Employer shall be entitled to rely on such statement) at the time elections are made under the Plan that it is reasonably expected based on circumstances at the time of the election that his or her contribution to the Dependent Care Expense Account for the Plan Year will not exceed the lowest of:

(a) $5,000 per calendar year (or $2,500 in the case where a separate federal income tax return is filed by a married Participant); or

(b) if the Participant is single or is married and earns less than his or her Spouse in a calendar year, the compensation paid to the Employee by the Employer as reflected on his or her Form W-2 for the year; or

(c) if the Participant is married and the Earned Income of his or her Spouse is less than the compensation paid to the Employee by the Employer in a calendar year, the Earned Income of the Spouse. If the Spouse is a full-time student or is physically or mentally incapable of caring for himself or herself, the Spouse will be deemed to have Earned Income (for each month that the spouse is a student or incapacitated) of $250 per month if the Employee has one Qualifying Individual for whom care is provided and of $500 per month if the Employee has two or more Qualifying Individuals for whom care is provided.

The Employer may require that the Participant and/or his or her Spouse certify to the Employer the amount of such spouse's expected Earned Income for the Plan Year in question and may require that the Participant provide documentary evidence of the amount certified in the form of an employment contract, paycheck stub, medical records (if the spouse is incapacitated) or a school enrollment form (if the spouse is a full-time student).
A Participant failing to follow the enrollment procedure established by the Plan Administrator during the initial Election Period, or any Participant failing to specify an amount of coverage, shall be deemed to have elected no coverage. A Participant failing to follow the enrollment procedure established by the Plan Administrator during any Reelection Period shall be deemed to have elected the same level of coverage as chosen in his or her most recent election.

Section 4. Funding. Benefits shall be funded by Contributions, as elected by the Participant, and shall be paid from the general assets of the Employer.

Section 5. Filing of Claims. In order to receive reimbursement, the Participant (or his or her beneficiary, in the event of the Participant's death) shall file a claim or claims with the Plan Administrator on a form provided for such purpose. The amount that may be submitted as a claim shall not be less than the minimum reimbursement amount established by the University unless the claim represents the final claim for a Plan Year. The claim(s) must be filed no later than September 30 of the Plan Year following the Plan Year during which the expense was incurred. In the case of a Participant who is actively participating in this Plan on June 30 of any Plan Year, a Dependent Care Expense that is incurred between July 1 and September 15 of the following Plan Year may be treated as being incurred either during the Plan Year preceding the date on which the Dependent Care Expense was incurred or during the Plan Year during which the Dependent Care Expense was incurred (provided the Participant has elected to participate in this Plan for such Plan Year), in accordance with rules prescribed by the Plan Administrator. Upon approval of a claim by the Plan Administrator, the Participant shall be entitled to reimbursement. Claim amounts exceeding a Participant's current Dependent Care Expense Account balance shall be reimbursed in the next month that the account balance is sufficient to pay such claims, but in no event shall the total dollar amount of approved claims for any Plan Year exceed the total amount allocated to such Account for the Plan Year. Any unclaimed balance remaining in the Participant's Dependent Care Expense Account for any Plan Year, attributable to Contributions made during such Plan Year, shall be forfeited and applied as provided in Section 4.8 of the Program. A Participant who has terminated service with the Employer shall be entitled to continue to make claims for Dependent Care Expenses incurred during the remainder of the Plan Year; provided, however, that reimbursement for such expenses shall not exceed the amount remaining in the Participant's Dependent Care Expense Account as of the date his or her participation in the Program ceased.

Section 6. Documentation Required. Prior to making any payment of benefits under the Program, the Plan Administrator will require the Participant to provide such evidence of Dependent Care Expenses as is sufficient to enable the Plan Administrator to determine that the Dependent Care Expenses qualify for reimbursement and to make an accurate determination of the amount of the benefit to be paid.

Section 7. Certification of Validity. An Employee submitting a claim for reimbursement of an expense shall certify, on the form on which such claim is made, that the expense is a covered expense within the meaning of Section 1 above. The Employer and the Plan Administrator shall be entitled to rely on such certification for all purposes.
Section 8. Identification of Dependent Care Provider. An expense shall not be a covered expense under this Plan unless:

(a) the name, address, and taxpayer identification number of the person performing the dependent care are included on the Employee's federal tax return for the calendar year coincident with the Plan Year; or

(b) if the dependent care provider is an organization described in section 501(c)(3) of the Code and exempt from tax under section 501(a) of the Code, the name and address of the provider are included on the Employee's federal tax return for the calendar year coincident with the Plan Year; or

(c) the Employee establishes to the satisfaction of the Internal Revenue Service that the Employee has exercised due diligence in attempting to provide the information described in subsections (a) and (b) above, and that such information cannot be obtained.

Section 9. Treatment of Employees Who Terminate or Otherwise Change Status. In the case of Employees whose employment with the Employer terminates during a Plan Year, or who otherwise cease to be Eligible Employees, or who have made an effective election under Section 5.2 of the Program to cease participation on a date other than the last day of a Plan Year, accruals of Employer Contributions shall cease as of the effective date of such change, but reimbursements with respect to prior accruals shall continue to be made through the September 30 following the end of the Plan Year for covered expenses incurred during the remainder of the Plan Year.

Section 10. Consequences of Reimbursement of Noncovered Expenses. In the event of a determination by the Plan Administrator, or by an appropriate governmental body, that reimbursements under this Plan are taxable to an Employee, such Employee shall pay:

(d) any state or federal income taxes due with respect to such amounts, together with any interest or penalties imposed thereon;

(e) the Employee's share (as determined in good faith by the Employer) of any FICA, FUTA, or state employee benefit contributions, which would have been withheld by the Employer had such amounts been paid as taxable cash compensation; and

(f) an amount (as determined in good faith by the Employer) equal to the portion allocable to the Employee of any penalties and interest payable by the Employer as a result of the failure to withhold and pay such amounts to the appropriate payee.

Section 11. Statement of Account. On or before January 31, the Plan Administrator shall furnish to each Participant who has elected a benefit under this Plan a written statement showing the amount of Contributions allocated to the Participant's Dependent Care Expense Account and reimbursements made to the Participant for the prior calendar year.

Section 12. Nondiscrimination. With respect to eligibility, contributions and benefits, the Plan shall satisfy the nondiscrimination provisions of section 129 of the Code to the extent
applicable. The Plan Administrator may prospectively limit, reallocate or deny any benefit, or recharacterize any contributions, to the extent necessary to avoid any such discrimination.
APPENDIX G

VISION PLAN

Section 1. **Eligibility.** Consistent with the provisions of Section 1.12, each Participant shall be eligible to elect any one of the benefits described in the applicable Contracts, except to the extent otherwise specified by the University, in its sole discretion.

Section 2. **Options and Coverage.** Each Participant shall elect a coverage option category and a coverage level as described in the enrollment materials provided by the Employer. The Participant may also elect to waive coverage under the Plan as provided on the benefit election form. Prior to the date the Participant commences coverage or in the event that a Participant fails to make a valid election during the Election Period or Reelection Period, the following rules shall apply:

(a) Prior to the date the Participant's coverage commences or if such individual had not followed the enrollment procedure established by the Plan Administrator with respect to this Plan for a previous Plan Year, he or she shall be deemed to have waived coverage under this Plan.

(b) If such individual had followed the enrollment procedure established by the Plan Administrator with respect to this Plan for a previous Plan Year, he or she shall be deemed to have elected the same coverage (including no coverage, if applicable) under this Plan as specified in his or her most recent election.

Section 3. **Funding.** Benefits shall be funded in accordance with the applicable Contract, the terms of which are incorporated herein by reference. The costs of such benefits shall be paid by the Participant in accordance with this Plan and according to the allocations made by the Participant under the Program, and in such amounts as are determined annually by the University prior to the Election or Reelection Period.

Section 4. **Benefits.** Vision benefits shall include the fee schedules for network or non-network vision care as outlined in the Summary Plan Description for Participants and, if coverage is so elected, for eligible Dependents in accordance with the terms of the applicable Contract.
APPENDIX H

LONG-TERM DISABILITY PLAN

ARTICLE I
HISTORY AND DEFINITIONS

Section 1.1. Plan History and Purpose. Prior to July 1, 2002, the University maintained the University of Pennsylvania Long-Term Total Disability Income Plan (the "LTD Plan") as a self-insured welfare benefit plan. The purpose of the LTD Plan is to provide eligible employees with continued income in the event of a total disability. Effective as of July 1, 2002, the University merged the LTD Plan into the Program, with the LTD Plan thereafter existing as a component Plan under the Program. The general provisions of the Program (including, without limitation, provisions relating to administration, claims administration, subrogation, amendment, and termination), shall apply to the LTD Plan to the extent not modified herein. If there is any conflict between this Appendix H and the Program, this Appendix H shall control.

The Hospital of The University of Pennsylvania and certain related entities, collectively referred to herein as the University of Pennsylvania Health System ("UPHS"), were covered by the LTD Plan up through June 30, 2002, at which time UPHS established a separate, insured plan for eligible employees of UPHS. Although the LTD Plan generally ceased coverage for UPHS employees, eligible employees of UPHS whose "Elimination Period" (as defined below) began before July 1, 2002, or who were receiving disability benefit under the LTD Plan on June 30, 2002, continue to be covered by the LTD Plan on and after July 1, 2002.

The LTD Plan as set forth in this Appendix H reflects the terms of the LTD Plan in effect as of May 1, 2003 (the "Effective Date").

This Appendix H was amended as of July 1, 2005 to change the definition of "Disability" or "Disabled."

Section 1.2. Definitions. Whenever used in the LTD Plan, the following capitalized terms shall have the following meanings. Capitalized terms not defined herein shall have the meaning given to them in the Program:

(a) "Benefit/Benefits" means the monthly benefit payable under Section 3.1 as a result of a Disability.

(b) "Disability" or "Disabled" means, for conditions occurring or reoccurring on or after July 1, 2005:

(1) First 24 Months. For the first 24-month period following the completion of the applicable Elimination Period, the term Disability or Disabled means the inability of an Eligible Employee to perform the material duties of his or her own occupation solely because of disease or injury. This includes situations where an Eligible Employee may be able to work but is unable to earn more than 80% of his or her pre-disability earnings performing the
material duties of his or her own occupation solely because of disease or injury.

(2) After 24 Months. For periods after the completion of the 24-month period described in paragraph (1), the term Disability or Disabled means the inability of an Eligible Employee to engage in any reasonable occupation appropriate to the individual by reason of education, training and experience solely because of a disease or injury. This includes situations where an Eligible Employee may be able to work but is unable to earn more than 80% of his or her pre-disability earnings performing the material duties of any occupation appropriate to the individual by reason of education, training and experience. For purposes of applying the requirements of this paragraph (2), determinations of whether an occupation is reasonable and appropriate to an individual by reason of education, training and experience shall be made by the Claims Administrator (and, where necessary, the Claims Administrator's vocational experts) in accordance with the Claims Administrator's non-discriminatory policies and procedures.

(3) Exclusions. Notwithstanding the provisions set forth in paragraphs (1) and (2), a disability relating to the following shall not constitute a "Disability" under the LTD Plan: (i) any disability which occurs during the first twelve months of employment and for which the Eligible Employee received medical treatment during the three months prior to the date the Employee becomes an Eligible Employee; (ii) service in the Armed Forces or Merchant Marines of the United States or any other country; (iii) warfare; (iv) willful participation in any criminal act; (v) intentionally self-inflicted injury not resulting from other medical or mental conditions; or (vi) use of drugs or narcotics or any other chemical substance or compound contrary to law.

(c) "Effective Date" means May 1, 2003.

(d) "Eligible Employee" means a full-time benefits eligible Employee who is a member of the faculty, or a full-time administrative, professional, or other staff Employee of the Employer. For this purpose, an Employee is considered to be "full-time" if he is regularly scheduled to work 35 or more hours per week, and/or satisfies such other requirements as may be set forth in the Employer's employment or personnel policies. The term "Eligible Employee" shall not include: (i) any employee covered by a collective bargaining agreement, unless that collective bargaining agreement provides for participation in the LTD Plan; (ii) any individual who performs services for the Employer as a leased employee within the meaning of Code section 414(n); or (iii) an independent contractor or any other person who is not treated by the Employer as an employee for purposes of withholding federal employment taxes, regardless of any contrary governmental or judicial determination relating to such employment status or tax withholding. If a court, the Internal Revenue Service, or any other enforcement authority or
agency shall find that an individual described in the preceding sentence should be treated as an Employee of a Participating Employer, such individual is expressly excluded from the definition of Eligible Employee and is expressly ineligible for benefits hereunder. The determination of whether an individual meets this definition of an Eligible Employee shall be made by the Plan Administrator in accordance with its uniform and nondiscriminatory procedures.

(e) "Elimination Period" means the day after the date on which the Disability has been continuous and total for six (6) months.

ARTICLE II
ELIGIBILITY AND COVERAGE

Section 2.1. Eligibility for Coverage. An Eligible Employee who was participating in the LTD Plan on the day before the Effective Date shall continue participating in the LTD Plan on the Effective Date. Each other Eligible Employee shall become covered under the LTD Plan on the date he or she becomes an Eligible Employee; provided, that such Eligible Employee is actively at work on such date. If such Eligible Employee is not actively at work on the date coverage otherwise would start, coverage under the LTD Plan shall start on the first date thereafter on which such Eligible Employee is actively at work.

Section 2.2. Coverage During Leave. Coverage under the LTD Plan shall continue during an approved leave of absence as determined by the Plan Administrator in a uniform and nondiscriminatory manner by reference to the Employer's employment and leave policies (including, without limitation, any limits on the length of an authorized leave of absence. If an Eligible Employee is covered by any other long term disability plan during an approved leave of absence, Benefits under the LTD Plan shall be offset by benefits under such other plan in accordance with Section 3.1(a)(3). During an approved leave of absence, the LTD Plan's coverage shall be at the same Benefit level in effect on the day immediately prior to the day the absence begins. Except as otherwise provided in the Employer's leave and employment policies, such covered absences shall include the following:

(a) an approved absence under the Family and Medical Leave Act of 1993;
(b) short term disability;
(c) a paid or unpaid leave of absence by reason of illness or injury up to twelve months;
(d) sabbatical;
(e) paid or unpaid military leave up to twelve months; and
(f) such other approved leaves as may be set forth in the Employer's leave and employment polices.

Section 2.3. Cessation of Coverage. Except as otherwise provided in the Employer's leave and employment policies, coverage under the LTD Plan for an Eligible Employee (other than an individual who is receiving Benefits under the LTD Plan) shall cease on the earliest of:
Section 2.4. Disability with Gradual Onset. Notwithstanding Section 2.3 above, an Eligible Employee who ceases coverage under the LTD Plan as a result of a transfer to part-time employment (that is, the Employee no longer is regularly scheduled to work 35 or more hours per week), and who subsequently becomes Disabled, may be eligible for Benefits under the LTD Plan if the onset of such Disability occurred while the Employee was an Eligible Employee.

Section 2.5. Ineligibility for Benefits. Notwithstanding anything herein to the contrary, any Employee who is discharged from employment with a Participating Employer or Affiliate because of fraud, dishonesty, or other gross misconduct (including, without limitation, embezzlement or material falsification of an employment application) shall not be eligible for Benefits under the LTD Plan.

ARTICLE III
BENEFITS

Section 3.1. Benefits Under Long-Term Disability Plan

(a) Cash Benefits

(1) Requirements. After the Effective Date, an Eligible Employee who is determined to be Disabled by the Plan Administrator and who otherwise satisfies the applicable requirements of the LTD Plan for payment of Benefits shall be entitled to receive Benefits for periods after the expiration of the Elimination Period.

(2) Amount. An Eligible Employee who meets the requirements of paragraph (a) above shall receive a monthly Benefit (subject to offset as described in paragraph (3) below) equal to the lesser of (1) $15,000 per month, or (2) 60% of the Eligible Employee's monthly "Benefits base," provided that in no event shall the
Eligible Employee's monthly Benefit, after application of all applicable offsets as described in Section 3.1(a)(3)(B) below be less than the greater of (1) 10% of the Eligible Employee's Benefits base, or (2) $100. "Benefits base" means the Eligible Employee's monthly base salary used by the Employer for purposes of conducting annual open enrollment for the Program for the Plan Year in which the Eligible Employee becomes Disabled. "Benefits base" is determined as of a set date before each Plan Year and excludes all extra compensation, such as bonuses, overtime, incentive compensation, summer teaching or research salaries, amounts earned for teaching responsibilities for executive education courses at The Wharton School, and evening school or College of General Studies salaries, but includes any additional salary paid to a faculty member for performing services as an administrator so long as the administrative appointment is for a period of not less than 12 months.

(3) Offsets.

(A) For Eligible Employees who became Disabled before the Effective Date, offsets due to "Other Benefits" (as defined in paragraph (B) below) which were in effect prior to the Effective Date shall remain unchanged after the Effective Date; provided, however, that Other Benefits which are new benefits granted after the Effective Date (except for new family Social Security benefits) shall be offset from future Benefits paid under the LTD Plan. For Eligible Employees who became Disabled on or after the Effective Date, Benefits shall be offset by Other Benefits as described in paragraph (B) below.

(B) "Other Benefits" are any income benefits, including retroactive lump sums, payable to the individual or the individual's family under the disability or retirement provisions of (i) the Social Security Act, (ii) the Railroad Retirement Act, (iii) Unemployment Compensation Acts or programs; (iv) Workers' Compensation and Occupational Diseases Acts; (v) a defined benefit retirement plan that provides disability payments; or (vi) any other law, plan, arrangement or policy (including any insurance policy) providing disability income or work loss benefits to the Disabled individual or the family of the Disabled individual on account of the Disabled individual's Disability. In the event that a Disabled individual is eligible for, but has waived participation or otherwise failed to apply for benefits under any of the programs described in (i) through (vi), such individual's Benefits shall be offset by the amounts that normally would have been awarded under any of those programs had the individual not waived participation or failed to apply. Also, and as described in more detail in Section 3.6, Benefits shall be offset by any settlement or damage award or lump sum payment payable to the Disabled Individual or the Disabled individual's family to the extent that such settlement or award or payment is attributable to (or in compensation for) lost earnings on account of the Disabled individual's Disability.

(C) Special Rule for Employees with Dual Appointment with CHOP - If a CHOP Eligible Employee (as defined below) receives an award of Social Security disability (or the amount of such an award is presumed under paragraph (3)(B) above), the
portion of the Social Security disability benefit that will be applied as an offset under paragraph (3)(A) above shall be determined by multiplying the Social Security disability benefit by a fraction, the numerator of which is the monthly benefits base under paragraph (2) above and the denominator of which is an amount equal to the sum of such monthly benefits base plus the monthly base salary used by CHOP for purposes of determining the monthly long term disability benefit under the CHOP Master Welfare Benefit Plan. All determinations relating to the calculation of this Social Security offset amount (including, without limitation, the amount of an Eligible Employee's CHOP monthly base salary) shall be made by the Plan Administrator in its sole discretion and in accordance with its uniform and nondiscriminatory procedures. For purposes of this paragraph (C), the term "CHOP Eligible Employee" means an Eligible Employee who (i) has a dual appointment with the University and The Children's Hospital of Philadelphia ("CHOP"), (ii) is covered by a long-term disability plan sponsored by CHOP, and (iii) is not covered by a long-term disability plan sponsored by the Clinical Practices of the University of Pennsylvania.

(4) Commencement of Cash Benefits. Benefits shall be payable starting with the first month following the later of (i) the expiration of the Elimination Period, or (ii) the date that the Plan Administrator determines that an individual is Disabled. If the Plan Administrator determines that an individual first became Disabled as of some prior date, the Plan Administrator may determine that Benefits shall be payable retroactively to such prior date; provided, that Benefits shall not be payable for any portion of the Elimination Period.

(5) Duration and Termination of Cash Benefit Payments. Disability Benefits hereunder cease as of the last day of the month following the earlier of:

(A) the date that a Disabled individual cease to be Disabled;

(B) the date that a Disabled individual fails (or refuses) to furnish proof to the Plan Administrator of his or her continuing Disability as required under Section 3.5;

(C) the date that a Disabled individual has received benefits for the maximum benefit period determined under the following table based on the Disabled individual's age when the disability began:

<table>
<thead>
<tr>
<th>Date Disability Begins</th>
<th>Maximum Benefit Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before Age 60</td>
<td>Through Social Security Normal Retirement Age</td>
</tr>
<tr>
<td>Age 60</td>
<td>84 months (7 years)</td>
</tr>
<tr>
<td>Age</td>
<td>Duration</td>
</tr>
<tr>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>61 months</td>
<td>72 months</td>
</tr>
<tr>
<td>62 months</td>
<td>60 months</td>
</tr>
<tr>
<td>63 months</td>
<td>48 months</td>
</tr>
<tr>
<td>64 months</td>
<td>36 months</td>
</tr>
<tr>
<td>65-69 months</td>
<td>24 months</td>
</tr>
<tr>
<td>70 or older</td>
<td>12 months</td>
</tr>
</tbody>
</table>

(D) the date of the Disabled individual's death; or

(E) the date the LTD Plan is terminated, or the date a Participating Employer ceases participation in the LTD Plan if it fails to continue to fund Benefits that are in pay status.

(b) Continuation of Other Benefits. A Disabled individual's rights to other Program benefits or any other benefits offered by the Employer shall be determined solely on the basis of the applicable terms of the Program or such other plans, policies or procedures governing the provision of such benefits as may be in effect from time to time.

Section 3.2. Rehabilitative Employment.

(c) Any individual receiving LTD Benefits is encouraged to engage in rehabilitative employment. Fifty percent (50%) of compensation earned from employment will be deducted from the LTD Benefits payable to the Disabled individual, provided, that in no event shall the Disabled individual's total gross income from the LTD Plan (including for this purpose any offset benefits taken into account under Section 3.1(a)(3)) and from compensation earned from employment exceed the Disabled individual's annual "benefits base" at the time he or she became Disabled.

(d) An individual receiving LTD Benefits for whom it is determined by the Plan Administrator that rehabilitation counseling would be effective must cooperate with such counseling. If lack of cooperation on the part of such individual occurs, LTD Benefits may be terminated by action of the Plan Administrator. For purposes of this Section 3.2(b), "lack of cooperation" shall mean behavior that obstructs, hinders, delays or interferes with activities that are designated by the Plan Administrator as steps in the rehabilitation counseling process.

Section 3.3. Recurrence of a Disability. Disability Benefits shall be restored to an individual who returns to active employment with the Employer or an Affiliate (or employment for an unrelated employer) following a period of absence due to a Disability if the individual suffers a recurrence of such Disability within 90 days (180 days for periods beginning on and after January 1, 2010) after returning to active employment.
Section 3.4. **Making an Application for Benefits.** Benefits under the LTD Plan are contingent upon a Disabled individual filing a timely and complete application for Benefits with the Plan Administrator (or its designee) in accordance with the Plan Administrator's uniform and nondiscriminatory procedures. Except as otherwise determined by the Plan Administrator, any such application for Benefits must be filed no later than 120 days after the end of the affected individual's Elimination Period.

Section 3.5. **Death During Application Process.** If the affected individual dies as a result of his or her Disability before the decision to pay Benefits has been made hereunder, such individual shall be deemed to have been Disabled, and any Benefits which would otherwise have been payable hereunder until his date of death shall be paid to such individual's estate.

Section 3.6. **Benefit and Disability Determinations and Continued Eligibility for Benefits.** All Disability and Benefit determinations under the LTD Plan shall be made by the Plan Administrator, in its sole discretion, in accordance with the uniform and nondiscriminatory procedures established by the Plan Administrator. Continued receipt of Benefits after the initial Disability determination shall be subject to such requirements as may be imposed by the Plan Administrator in accordance with the uniform and nondiscriminatory procedures established by the Plan Administrator. These requirements may include, without limitation, (i) requiring Disabled individuals to submit to periodic medical exams that confirm the continuing nature of the Disability, and/or (ii) requiring Disabled individuals to provide certain information, such as Federal Income Tax returns, to verify their employment status and continuing Disability. If a Disabled individual fails to submit requested information or refuses to undergo a medical examination as requested by the Plan Administrator or, based upon submitted information or a medical examination, is determined to no longer be Disabled, Benefits shall cease as required under Section 3.1(a)(5).

**ARTICLE IV**

**FUNDING**

Benefits are self-insured and paid by the Employer. The Plan Administrator has entered into a Contract with a third-party administrator to provide certain claims determination and other administrative services with respect to the LTD Plan. The University may at any time change the source or manner of funding Benefits under the LTD Plan, may replace the LTD Plan with a new plan that is insured or uninsured, or may reduce its contributions, require Contributions by the Participant, or change Benefits or eliminate Benefits.
APPENDIX I

LONG TERM CARE PLAN

Section 1. **Eligibility.** Consistent with the provisions of Section 1.12, each Participant shall be eligible to elect the benefits described in the applicable Contract, except to the extent otherwise specified by the University, in its sole discretion.

Section 2. **Options and Coverage.** Each Participant shall elect a coverage option category and a coverage level as described in the enrollment materials provided by the Employer. The Participant may also elect to waive coverage under the Plan as provided on the benefit election form. Prior to the date the Participant commences coverage or in the event that a Participant fails to make a valid election during the Election Period or Reelection Period, the following rules shall apply:

(a) Prior to the date the Participant's coverage commences or if such individual had not followed the enrollment procedure established by the Plan Administrator with respect to this Plan for a previous Plan Year, he or she shall be deemed to have waived coverage under this Plan.

(b) If such individual had filed a completed election form with respect to this Plan for a previous Plan Year, he or she shall be deemed to have elected the same coverage (including no coverage, if applicable) under this Plan as specified on his or her most recently filed election form.

Section 3. **Funding.** Benefits shall be funded in accordance with the applicable Contract, the terms of which are incorporated herein by reference. The costs of such benefits shall be paid by the Participant in accordance with this Plan and according to the allocations made by the Participant under the Program, and in such amounts as are determined annually by the University prior to the Election or Reelection Period.

Section 4. **Benefits.** Long term care benefits shall be as outlined in the Summary Plan Description for Participants and, if coverage is so elected, for eligible Dependents in accordance with the terms of the applicable Contract.