IVY TECH COMMUNITY COLLEGE
HEALTH AND DENTAL CARE PLAN

Effective as of January 1, 2021

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IVY TECH COMMUNITY COLLEGE
HEALTH AND DENTAL CARE PLAN

ARTICLE I.
GENERAL PROVISIONS

The Ivy Tech Community College Health and Dental Care Plan ("Plan") was established by Ivy Tech Community College of Indiana (the "College") to provide employee health and dental benefits to eligible employees and retirees of the College and their eligible dependents. The Plan is being amended and restated in its entirety, effective January 1, 2021.

ARTICLE II.
DEFINITIONS AND RULES OF INTERPRETATION

Section 2.01. Definitions.

When used herein, the following terms shall have the following meanings when the first letter of the term is capitalized:

(a) "Actively at Work" means an Employee is capable of carrying out his or her regular job duties and is present at his or her place of work on regularly scheduled working days. Employees who are absent from work due to a health factor, as defined in HIPAA, or disability and those on maternity leave or scheduled vacation are considered Actively at Work.

(b) "Administrator" means the College, as provided in Section 12.01. The Administrator shall serve as the plan administrator.

(c) "Appeal" means review by the Claims Supervisor of a Denial.

(d) "Child" means an Eligible Employee's or Eligible Retiree's:

(1) biological child;

(2) stepchild;

(3) legally adopted child (or child placed for adoption); or

(4) eligible foster child.

An "eligible foster child" under paragraph (4) means a child placed with the Eligible Employee or Eligible Retiree by an authorized placement agency or by judgment, decree, or other order of a court of competent jurisdiction.

(e) "Claimant" means an individual who makes a claim for benefits under Article XIII. For purposes of Article XIII, references to a Claimant include a Claimant's authorized representative.

(f) "Claims Supervisor" means a person, firm, or corporation that has agreed to provide technical or administrative services and advice in connection with the operation of one or more

benefits provided under the Plan, and to perform such other functions, including processing and payment of claims, as may be delegated to it under such contract. The Claims Supervisor may review claims, Appeals, and, if applicable, coordinate External Reviews, as provided by the Plan.

(g) "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

(h) "Code" means the Internal Revenue Code of 1986, as amended from time to time.

(i) "College" means Ivy Tech Community College of Indiana.

(j) "Covered Person" means any Eligible Employee, Eligible Retiree, Surviving Spouse, or Dependent, who is covered under the Plan.

(k) "Denial" means a denial, reduction, termination, or failure to provide or make payment (in whole or in part) for a benefit, including determinations based on eligibility, and, with respect to Health Benefits, a denial, reduction, termination or failure to provide or make payment for a benefit based on utilization review or a failure to cover a benefit because it is determined to be experimental or investigational or not medically necessary. With respect to the Health Benefits, it also means a Rescission whether or not, in connection with the Rescission, there is an adverse effect on any particular health benefit at the time.

(l) "Dental Benefits" means the group dental plan benefits established and maintained by the College and provided under the Plan, as amended from time to time.

(m) "Dependent" means:

(1) a Spouse;

(2) a Child until the end of the month in which the Child attains age 26; and

(3) a Child after the end of the month in which the Child attains age 26, if the Child is (i) a Dependent covered under the Health Benefits prior to attaining age 26, (ii) claimed as a tax dependent on the Eligible Employee's or Eligible Retiree's tax return, and (iii) permanently and totally disabled. A Child is permanently and totally disabled if he or she is unable to engage in any substantial gainful activity due to a medically-determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of 12 months or more. Proof of permanent and total disability must be provided to the Claims Supervisor with 120 days of the Child's 26th birthday and proof of continued permanent and total disability may be required by the Claims Supervisor on an annual basis thereafter, which may include examination of the Child by a physician selected by the College, which cost will be borne by the Eligible Employee, Eligible Retiree, or the Dependent. The College may terminate coverage under the Plan effective as of the 120th day following the date of the Claims Supervisor's request of additional proof, if such proof is not furnished as requested.

(n) "Electronic Protected Health Information" or "EPHI" means "electronic protected health information" as defined at 45 CFR § 160.103, which, generally, means Protected Health

Information that is transmitted by, or maintained in, electronic media. For these purposes, "electronic media" means: (i) electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or (ii) transmission media used to exchange information already in electronic storage media (*e.g.*, the internet, extranet, leased lines, dial up lines, private networks, and the physical movement of removable/transportable electronic storage media).

(o) "Eligible Employee" means the following:

(1) An Employee who is employed with the College in one of the following categories:

(A) Faculty – employed as a full-time, benefits-eligible faculty member with the College who is working at least 80% FTE, generally on a nine month (academic year) basis for fall and spring semesters and a minimum of a 50% summer contract (including summer extended appointments), if enrollment is sufficient;

(B) Support employee – employed on an hourly basis as a full-time, benefits-eligible support staff with the College who is regularly scheduled to work at least 32 hours per week in a position that is typically staffed year-round on an ongoing basis;

(C) Administrative employee – employed on a salaried basis as a full-time, benefits-eligible administrative employee with the College who is regularly scheduled to work at least 32 hours per week in a position that is typically staffed year-round on an ongoing basis; and

(D) Grandfathered employee – covered under the Plan as an Eligible Employee on June 30, 2013, so long as he or she remains continuously covered under the Plan and continues to satisfy the definition of Eligible Employee under the terms of the Plan in effect on June 30, 2013.

(E) LTD participant – covered under the Plan on December 31, 2020, as an Eligible Employee who is eligible for and receiving long-term disability benefits from the College, so long as he or she remains continuously covered under the Plan. A LTD participant will continue to be eligible for coverage under the terms of the Plan in effect on December 31, 2020.

(2) Except as provided in paragraph (3), an Eligible Employee shall not include an individual in one of the following categories:

(A) Adjunct faculty;

(B) Non-benefits eligible part-time support employees who are employed to work a period of 12 months or more and are regularly scheduled to work less than 32 hours per week;

(C) Non-benefits eligible temporary support employees who are employed to work for less than 12 months per year and do not exceed 1,456 hours worked in a 12-month period;

(D) Non-benefits eligible part-time administrative employees who are employed to work 12 months or more and are regularly scheduled to work less than 32 hours per week;

(E) Non-benefits eligible temporary administrative employees who are employed to work less than 12 months per year and do not exceed 1,456 hours worked in a 12 consecutive month period;

(F) Volunteers with the College;

(G) Any person who is a member of the state or campus Board of Trustees or any committee approved by such Board of Trustees, who is not otherwise an Eligible Employee;

(H) Any person employed pursuant to a written agreement which provides that such person will not be eligible for any benefits from the College;

(I) Any leased employees, as defined under Code Section 414(n), or contract employees;

(J) Any person designated in good faith by the College as an independent contractor, regardless of whether such person is later determined to be a common law employee for tax purposes; or

(K) Nonresident aliens who receive no earned income (within the meaning of Code Section 911(d)(2)) from the College which constitutes income from sources within the United States under Code Section 861(a)(3).

(3) Notwithstanding paragraph (2), for purposes of eligibility to enroll in Health Benefits, an Eligible Employee shall include an individual employed by the College who is determined to be a full-time employee pursuant to the College's policy for determining full-time employment status under Internal Revenue Code Section 4980H, as attached hereto and incorporated herein under Appendix A, and as amended from time to time.

(p) "Eligible Retiree" means an individual who meets the criteria of subparagraphs (1), (2), or (3) below:

(1) Regular Retiree –

(A) An Eligible Employee who is a Covered Person who retires from the College on or after age 55 and before age 65 with 10 or more years of continuous benefits-eligible service with the College, or

(B) An Eligible Employee who is a Covered Person who retires from the College at age 65 or older with five or more years of continuous benefits-eligible service with the College.

(2) 75 Plan Retiree – After being continuously employed in a benefits-eligible position on or prior to December 31, 2008, an Eligible Employee who is a Covered Person who retires from the College on or after age 55 and before age 65 with a combined age and years of continuous benefits-eligible service with the College equal to at least 75.

(3) 75 Point ERIP Retiree – An Eligible Employee who is a Covered Person whose age and completed years of service with the College as of December 31, 2013, equals at least 75 and who retires under the Ivy Tech Community College of Indiana 75 Point Early Retirement Incentive Plan.

(q) "Employee" means a common law employee of the College.

(r) "External Review" means a review of a Denial (including a Final Denial) of Health Benefits pursuant to the External Review process described in Section 13.03.

(s) "Final Denial" means a Denial of Health Benefits that has been upheld by the Claims Supervisor at the completion of the internal claims procedure pursuant to Section 13.02, or a Denial of Health Benefits with respect to which the internal claims procedure has been deemed exhausted as described under Section 13.02 (a "deemed Final Denial").

(t) "Final External Review Decision" means a determination by an Independent Review Organization at the conclusion of External Review.

(u) "Flexible Benefit Plan" means the "Ivy Tech Community College Flexible Benefit Program and Summary" established and maintained by the College, as amended from time to time.

(v) "FMLA" means the Family and Medical Leave Act of 1993, as amended from time to time.

(w) "Health Benefits" means the group medical plan benefits (including prescription drug benefits) established and maintained by the College and provided under the Plan, as amended from time to time.

(x) "Health Care Operations" means "health care operations" as defined by 45 CFR § 164.501, as amended. Generally, Health Care Operations include, but are not limited to, the following activities taken by or on behalf of the Plan:

(1) Quality assessment;

(2) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(3) Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(4) Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

(5) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(6) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of Payment methods or coverage policies;

(7) Business management and general administrative activities of the Plan, including, but not limited to:

(A) Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or

(B) Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;

(C) Resolution of internal grievances;

(D) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, shall become a covered entity; and

(8) Any other activity considered to be a "health care operation" activity pursuant to 45 CFR § 164.501.

(y) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

(z) "Independent Review Organization" or "IRO" means an entity that conducts independent External Reviews of Denials and Final Denials.

(aa) "Individual" means any person who is the subject of Protected Health Information.

(bb) "Payment" means "payment" as defined by 45 § CFR 164.501, as amended. Generally, Payment activities include, but are not limited to, activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an Individual to whom health care is provided (except as may be prohibited under 45 CFR § 164.502(a)(5)(i)). These activities include, but are not limited to, the following:

(1) Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and copayments as determined for an Individual's claim);

(2) Coordination of benefits;

(3) Adjudication of health benefit claims (including Appeals and other payment disputes);

(4) Subrogation of health benefit claims;

(5) Establishing Eligible Employee or Eligible Retiree contributions;

(6) Risk adjusting amounts due based on an Eligible Employee's or Eligible Retiree's health status and demographic characteristics;

(7) Billing, collection activities and related health care data processing;

(8) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to an Eligible Employee's or Eligible Retiree's inquiries about payments;

(9) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(10) Medical necessity reviews or reviews of appropriateness of care or justification of charges;

(11) Utilization review, including precertification, preauthorization, concurrent review and retrospective review;

(12) Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following Protected Health Information may be disclosed for Payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan);

(13) Reimbursement to the Plan; and

(14) Any other activity considered to be a "payment" activity pursuant to 45 CFR § 164.501.

(cc) "Plan" means the "Ivy Tech Community College Health and Dental Care Plan," as set forth in this document, as amended from time to time.

(dd) "Plan Year" means January 1 through December 31.

(ee) "Post-Service Claim" means any claim for a benefit that is not an Urgent Care Claim or a Pre-Service Claim.

(ff) "Pre-Service Claim" means any claim for a benefit whereby the Plan conditions receipt of such benefit, in whole or in part, on approval of the benefit prior to obtaining care.

(gg) "Privacy Regulations" mean the regulations under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164, as amended).

(hh) "Protected Health Information" means "protected health information" as defined at 45 CFR § 164.501 which generally means information (including demographic information) that: (i) identifies an Individual (or with respect to which there is a reasonable basis to believe the information can be used to identify an Individual); (ii) is created or received by a health care provider, a health plan, or a health care clearinghouse; and (iii) relates to the past, present, or future physical or mental health or condition of an Individual; the provision of health care to an Individual; or the past, present, or future Payment for the provision of health care to an Individual.

(ii) "Rescission" means a cancellation or discontinuance of Health Benefits coverage that has retroactive effect. A Rescission does not include the cancellation or discontinuance of Health Benefits coverage that (i) has only a prospective effect or (ii) is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of such coverage.

(jj) "Section" means, when not preceded by the terms Code, a section of the Plan.

(kk) "Security Incident" means "security incident" as defined at 45 CFR § 164.304, which generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(ll) "Security Regulations" mean the regulations under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Parts 160 and 164, as amended).

(mm) "Service in the Uniformed Services" means (i) the performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, and National Guard duty under Federal law, (ii) a period for which an Eligible Employee is absent from a position of employment for the purpose of an examination to determine the fitness of the Eligible Employee to perform any such duty, (iii) a period for which the Eligible Employee is absent from employment to perform funeral honors duty as authorized by law, and (iv) service as an intermittent disaster-response appointee upon activation of the National Disaster Medical System ("NDMS") or as a participant in an authorized training program.

(nn) "Spouse" means a person to whom an Eligible Employee or Eligible Retiree is legally married under federal tax law (unless the Eligible Employee or Eligible Retiree is legally separated from such person under a decree of divorce or separate maintenance), and who is either a citizen, resident alien, or national of the United States.

(oo) "Summary Health Information" means "summary health information" as defined by 45 CFR § 164.504(a), as amended, which generally is information that may be individually identifiable health information, and:

(1) that summarizes the claims history, claims expenses, or type of claims experienced by Individuals for whom the College has provided health benefits under a group health plan; and

(2) from which the information described at § 164.514(b)(2)(i) of the Privacy Regulations has been deleted, except that the geographic information described in § 164.514(b)(2)(i)(B) of the Privacy Regulations need only be aggregated to the level of a five digit zip code.

(pp) "Surviving Spouse" means the Spouse of a person who, at the time of his or her death, was an Eligible Retiree.

(qq) "Uniformed Service" means the Armed Forces, the Army National Guard, the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commission corps of the Public Health Service, and any other category of persons designated by the President of the United States of America in time of war or emergency. For purposes of USERRA coverage only, services as an intermittent disaster response appointee of the NDMS when federally activated or attending authorized training in support of a Federal mission is deemed Service in the Uniformed Services, although such appointee is not a member of the "uniformed services" as defined by USERRA.

(rr) "Urgent Care Claim" means any claim for medical care or treatment where the failure to make a non-urgent care determination quickly (i) could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or (ii) in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(ss) "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

Section 2.02. Rules of Interpretation.

In interpreting the Plan, the following rules of interpretation shall apply:

(a) The Plan shall be construed, enforced, and administered and the validity thereof determined in accordance with the applicable provisions of the Code, and, to the extent not inconsistent with the Code, in accordance with the laws of the State of Indiana.

(b) Any reference to a Section of the Code shall be deemed a reference to any comparable or succeeding provision of any legislation that amends, supplements, or replaces such Section.

(c) Words used herein in the masculine gender shall be construed to include the feminine gender where appropriate and words used herein in the singular or plural shall be construed as being in the plural or singular where appropriate.

(d) Headings and subheadings are inserted for convenience and are not to be considered in the construction of any provision of the Plan.

(e) If a provision of the Plan is held illegal or invalid for any reason, that provision shall be deemed null and void, but the invalidation of that provision shall not otherwise impair or affect the Plan.

ARTICLE III.
BENEFITS

Section 3.01. Plan Benefits.

(a) The Plan provides Health Benefits and Dental Benefits, as set forth in Schedule A, to Eligible Employees, Eligible Retirees, Surviving Spouses, and their Dependents. No Eligible Employee, Eligible Retiree, Surviving Spouse, or his or her Dependents shall have any vested interest in any benefit under the Plan.

(b) The Health Benefits and Dental Benefits may be provided by the College on a fully insured, partially insured, or uninsured basis, as determined by the College in its sole discretion, and as reflected on Schedule A. The College may modify, add, and/or terminate the Health Benefits and Dental Benefits provided under the Plan by amending Schedule A at any time, which revised Schedule shall become a part of the Plan. Any such modified or additional benefit shall be subject to all of the terms and conditions of the Plan.

Section 3.02. Incorporation of All Relevant Benefit Documents.

(a) All written documents relating to the Health Benefits and Dental Benefits are set forth in the Plan and Schedule B, which documents are incorporated herein by reference and made a part of the Plan. To reflect any change to the Health Benefits and Dental Benefits set forth in Schedule A, the College may modify the written documents incorporated under the Plan by amending Schedule B at any time, which revised Schedule shall become a part of the Plan.

(b) No benefit shall be paid or made available to any Eligible Employee, Eligible Retiree, Surviving Spouse, or his or her Dependents, except as may be specifically provided by the College under the Plan and the documents incorporated herein.

(c) Unless specifically stated otherwise in the Plan, any conflict between the provisions of the Plan and the documents incorporated herein shall be resolved in favor of the Plan.

ARTICLE IV.
ELIGIBILITY, ENROLLMENT, AND TERMINATION

Section 4.01. General Rules of Eligibility.

(a) General. An Eligible Employee, Eligible Retiree, or Surviving Spouse may separately elect to enroll in Health Benefits and Dental Benefits for himself or herself and his or her Dependents, subject to the eligibility restrictions set forth in this Section 4.01.

(b) Working Spouse Rule. A Spouse who is or was employed by an employer other than the College and who is eligible through that employment or former employment for coverage (other than COBRA coverage) under a comprehensive group medical plan and/or group dental plan must elect such coverage in order to be eligible for Health Benefits or Dental Benefits, respectively. Coverage under the Plan will be secondary to coverage that the Spouse elects through his or her other employment or former employment. A Spouse shall be treated as eligible for other coverage under a comprehensive group medical plan and/or group dental plan, as applicable, even if the Spouse has opted not to be covered under such plan or has received a cash payment for opting out of such coverage. The restriction under this paragraph shall not apply if the Spouse's other employer or former employer does not pay at least 50% of the premium cost for the other coverage. In addition, the restriction under this paragraph shall not apply with respect to Dental Benefits if the group dental plan offered by the other employer or former employer does not coordinate benefits with other employer-sponsored dental coverage.

(c) Married Employees. If two Employees are married to one another, each Employee must be covered as an Eligible Employee, and one may not be covered as a Dependent of the other. A Child of two Eligible Employees will be considered a Dependent of only one Eligible Employee.

(d) Outside Service Area. A Dependent Child who resides outside of the Plan's service area for Health Benefits due to such Child attending an educational institution or residing with the Eligible Employee's former spouse is eligible to receive Health Benefits under the Plan at the network level. Claims are limited to the Plan's maximum allowed amount for network benefits and are subject to applicable cost sharing requirements. The Eligible Employee or Dependent Child is responsible for any amount in excess of the Plan's maximum allowed amount.

(e) Proof of Dependent Eligibility. An Eligible Employee or Eligible Retiree is required to submit proof of eligibility (and continued eligibility) for any Dependent as required by the Administrator or Claims Supervisor. Failure to provide this information could result in termination of a Dependent's coverage. The Eligible Employee or Eligible Retiree will be liable for any costs, fees, or expenses incurred by the College if he or she claims a Dependent who is determined to be ineligible.

(f) Rehired Employees. An Employee who was a Covered Person, terminated employment with the College, and then returns to employment with the College must again meet all eligibility requirements. For purposes of Health Benefits only, whether the Employee is treated as a new Employee upon reemployment shall be determined under the rehire rules provided under the College's policy for determining full-time employment status under Internal Revenue Code

Section 4980H, as attached hereto and incorporated herein under Appendix A, and as amended from time to time.

Section 4.02. Enrollment in Active Coverage.

(a) Initial Election.

(1) An Eligible Employee may make an initial election to receive coverage under the Plan for Health Benefits and/or Dental Benefits on behalf of himself or herself and his or her Dependents by completing an online election form via the College's benefits administration system and by agreeing to make any required contributions for coverage.

(2) Coverage of an Employee and his or her Dependents, if applicable, is effective as of the first day the Employee is an Eligible Employee, provided that the enrollment process is completed by the Employee within 31 days of becoming an Eligible Employee and the Eligible Employee is Actively at Work on such date; otherwise, coverage will be effective on the first day he or she is Actively at Work thereafter.

(3) If an initial election is not timely made, the Eligible Employee will be deemed to have waived coverage for himself or herself and his or her Dependents until the next annual enrollment opportunity or special enrollment opportunity, as applicable.

(b) Annual Enrollment.

(1) An annual enrollment will occur in the fall of each calendar year, with the new election effective as of first day of the following Plan Year (January 1). An Eligible Employee or Covered Person must complete an online election form via the College's benefits administration system to enroll in Health Benefits and Dental Benefits (or make changes to existing benefit elections) for the next Plan Year and must agree to make any required contributions for coverage.

(2) Unless otherwise communicated to Employees by the Administrator, an Eligible Employee who is a Covered Person who does not make an annual enrollment election will be deemed to have made an election to continue his or her current Health Benefits and/or Dental Benefits for the next Plan Year. An Eligible Employee who is not a Covered Person under the Plan and who does not make an annual enrollment election will be deemed to have waived coverage under the Plan for the next Plan Year.

(c) Special Enrollment. An Eligible Employee may elect to enroll himself or herself and/or his or her Dependents in coverage prior to the next annual enrollment if the Eligible Employee and/or his or her Dependents are entitled to a special enrollment and meet the requirements described subparagraphs (1), (2), or (3), as applicable. If a special enrollment election is not timely made as provided below, the Eligible Employee will be deemed to have waived coverage for himself or herself and his or her Dependents, as applicable, until the next annual enrollment opportunity.

(1) *Acquisition of a New Dependent*. If an Eligible Employee is a Covered Person or is not a Covered Person because he or she previously declined coverage for any

reason, and if such Eligible Employee acquires a new Dependent through marriage, birth, adoption, or placement for adoption, the Eligible Employee may enroll himself or herself in coverage under the Plan, if not already enrolled, and may also enroll his or her Spouse, the newly acquired Child, and/or any existing Child.

An Eligible Employee who is eligible for this special enrollment must (i) complete the online election form via the College's benefits administration system within 31 days after the marriage, birth, adoption, or placement for adoption, as applicable; (ii) agree to make any required contributions; and (iii) provide supporting documentation as requested by the College or Claims Supervisor. In no event may an Eligible Employee enroll a Dependent if the Eligible Employee is not already a Covered Person, or is not contemporaneously enrolling himself or herself as a Covered Person. Coverage will be effective as of the date of the marriage, birth, adoption, or placement for adoption, as applicable.

(2) *Loss of Other Coverage*. An Eligible Employee who is otherwise eligible for coverage under the Plan may enroll as a Covered Person, and a Dependent of an Eligible Employee who is otherwise eligible for coverage under this Plan may be enrolled by the Eligible Employee as a Covered Person, if the following requirements are met:

(A) The Eligible Employee previously declined coverage under this Plan for himself or herself and/or his or her Dependents because either the Eligible Employee or his or her Dependents, as applicable, had coverage under another group health plan or other health insurance;

(B) The Eligible Employee and/or his or her Dependents actually had other health coverage at the time coverage under this Plan was declined; and

(C) The other health coverage is lost due to the exhaustion of a COBRA continuation period, loss of eligibility under the other coverage, or cessation of employer contributions to the other coverage.

For purposes of this subsection, "exhaustion of a COBRA continuation period" means that an individual's COBRA continuation period ceases for any reason other than either failure of the individual to pay premiums on a timely basis or for cause. For purposes of this subsection, "loss of eligibility" includes a loss of coverage as a result of legal separation, divorce, cessation of dependent status (due, for example, to reaching the maximum age for Child coverage), death, termination of employment (other than for cause), reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing. "Loss of eligibility" also includes being a member of a class for which the plan no longer offers coverage. "Loss of eligibility" does not occur if the individual failed to pay premiums on a timely basis or if coverage was terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan).

An Eligible Employee who is eligible for this special enrollment must (i) complete the online election form via the College's benefits administration system within 31 days

after the loss of other coverage; (ii) agree to make any required contributions; and (iii) provide supporting documentation as requested by the College or Claims Supervisor. In no event may an Eligible Employee enroll a Dependent if the Eligible Employee is not already a Covered Person, or is not contemporaneously enrolling himself or herself as a Covered Person. Coverage will be effective as of the first day after the loss of coverage.

(3) *Medicaid and CHIP*. An Eligible Employee who is otherwise eligible for coverage under the Plan may enroll as a Covered Person, and a Dependent of an Eligible Employee who is otherwise eligible for coverage under this Plan may be enrolled by the Eligible Employee as a Covered Person, in the following two circumstances:

(A) The Eligible Employee and/or his or her Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act ("Medicaid") or a state children's health plan under Title XXI of the Social Security Act ("CHIP"), and coverage under such plans is lost due to a loss of eligibility for such coverage; or

(B) The Eligible Employee and/or his or her Dependent become eligible for premium assistance under Medicaid or CHIP with respect to coverage under the Plan (including any waiver or demonstration project conducted under or in relation to such plan).

An Eligible Employee who is eligible for this special enrollment must (i) complete the online election form via the College's benefits administration system within 60 days after the loss of Medicaid or CHIP coverage or eligibility for premium assistance, as applicable; (ii) agree to make any required contributions; and (iii) provide supporting documentation as requested by the College or Claims Supervisor. In no event may an Eligible Employee enroll a Dependent if the Eligible Employee is not already a Covered Person, or is not contemporaneously enrolling himself or herself as a Covered Person. Coverage will be effective as of the first day after the loss of coverage or the effective date of premium assistance, as applicable.

(d) Coordination With Flexible Benefit Plan. Notwithstanding anything in the Plan to the contrary, the Plan will be administered consistently with the Flexible Benefit Plan with respect to mid-year election changes on account of changes in status and other applicable events. To the extent that an Eligible Employee is permitted to make a mid-year election change under the Flexible Benefit Plan with respect to Health Benefits and/or Dental Benefits, a consistent coverage change will be permitted under this Plan, effective as of the date of the event.

Section 4.03. Termination of Active Coverage and Leaves of Absence.

(a) General. The termination provisions of this Section are subject to any exceptions provided in Article V (Eligible Retirees and Surviving Spouses), Article VI (COBRA), Article VII (FMLA), and Article X (USERRA).

(b) Termination of Employee Coverage. Coverage of an Eligible Employee will terminate under the Plan as of the earliest to occur of the following:

(1) The date the Employee terminates employment with the College.

(2) The date the Employee is no longer an Eligible Employee.

(3) The date on which the Employee fails to pay contributions required for coverage for Health Benefits and/or Dental Benefits or fails to make satisfactory arrangements with the College to pay such contributions.

(4) The date the Employee becomes a full-time member of the armed forces.

(5) The date on which the Employee engages in fraudulent conduct or furnishes fraudulent or misleading material information relating to claims or application for coverage with respect to Health Benefits and/or Dental Benefits.

(6) The date of the Employee's death.

(7) The date on which the Plan or underlying Health Benefits or Dental Benefits terminate.

(c) Leaves of Absence. Notwithstanding paragraph (b), coverage will continue for a an Eligible Employee who is on an approved paid or unpaid leave of absence, provided the Eligible Employee timely remits any premium payment required pursuant to the College's applicable leave policy. If the applicable leave policy requires an Eligible Employee on leave to pay more for coverage than an active Eligible Employee, the Eligible Employee (and his or her Dependents) will be offered the opportunity to elect COBRA coverage at the beginning of the leave instead of continuing active coverage. An election to continue active coverage under the Plan shall be in lieu of any COBRA coverage to which the Eligible Employee would otherwise be entitled.

(d) Termination of Dependent Coverage. Coverage of an Eligible Employee's Dependent will terminate under the Plan as of the earliest to occur of the following:

(1) The date the Employee's coverage terminates under paragraph (b).

(2) The date the Dependent no longer meets the definition of a Dependent under the Plan.

(3) The date on which the Employee fails to pay contributions required for Dependent coverage for Health Benefits and/or Dental Benefits or fails to make satisfactory arrangements with the College to pay such contributions.

(4) The date of the Dependent's death.

(5) The date on which the Plan or underlying Health Benefits or Dental Benefits terminate, or, if earlier, the date the Plan discontinues Dependent coverage.

An Eligible Employee must notify the College immediately if a Dependent ceases to meet the eligibility requirements under the Plan. Failure to timely provide such notice will be deemed by the College to be an act that constitutes fraud and an intentional misrepresentation of material

fact prohibited by the Plan that may result in a retroactive termination of coverage. The Eligible Employee will be responsible for payment for any services incurred by his or her Dependent after the Dependent ceases to meet the eligibility requirements.

ARTICLE V.
ELIGIBLE RETIREES AND SURVIVING SPOUSES

Section 5.01. Application.

(a) An Eligible Employee who is a Covered Person is entitled to continue coverage under the Plan for himself or herself and his or her Dependents upon becoming an Eligible Retiree in accordance with the terms of this Article. If timely elected, coverage will begin the date immediately following the last day of coverage as an Eligible Employee.

(b) A Surviving Spouse is entitled to continue coverage under the Plan for himself or herself and his or her Dependents upon the death of an Eligible Retiree who was a Covered Person at his or her death, in accordance with the terms of this Article. If timely elected, coverage will begin the date immediately following the date of the Eligible Retiree's death.

(c) The Health Benefits and Dental Benefits provided under the Plan to Eligible Retirees, Surviving Spouses, and their Dependents are the same Health Benefits and Dental Benefits provided to Eligible Employees and their Dependents, provided that Eligible Retirees and Surviving Spouses may be required to pay the full cost of coverage. Any changes in the benefits offered under the Plan to active Eligible Employees and their Dependents will be applicable to Eligible Retirees, Surviving Spouses, and their Dependents.

Section 5.02. Eligible Retiree Coverage.

An Eligible Retiree's coverage under the Plan is determined based on the Eligible Retiree's age and whether the Eligible Retiree is a "Regular Retiree," a "75 Plan Retiree," or a "75 Point ERIP Retiree," as those terms are defined in Section 2.01 under the definition of Eligible Retiree.

(a) Regular Retiree Coverage. A Regular Retiree may elect to continue the same coverage under the Plan that was in effect at the time of retirement. Regular Retirees are required to pay 100% of the cost of coverage for themselves and their Dependents. At age 65, a Regular Retiree may elect between continued coverage under this Plan (100% paid by the Regular Retiree), where coverage under this Plan is secondary to Medicare, or a separate Medicare Supplement Plan offered by the College.

(b) 75 Plan Retiree Coverage. A 75 Plan Retiree may elect to continue the same coverage under the Plan that was in effect at the time of retirement. 75 Plan Retirees are required to pay the same amount for coverage that is charged to active Employees for themselves and their Dependents until they attain age 65. A 75 Plan Retiree who is (i) covered under the 75 Plan and attains age 65, or (ii) eligible for but not covered under the 75 Plan and retires from the College after attaining age 65, may elect between continued coverage under this Plan (100% paid by the 75 Plan Retiree), where coverage under this Plan is secondary to Medicare, or a separate Medicare Supplement Plan offered by the College.

(c) 75 Point ERIP Retiree Coverage. A 75 Point ERIP Retiree may elect to continue the same coverage under the Plan that was in effect at the time of retirement. 75 Point ERIP Retirees are required to pay the same amount for coverage that is charged to active Employees for themselves and their Dependents until they are within three months of age 65, at which point they are required to pay 100% of the cost of coverage for themselves and their Dependents. A 75 Point ERIP Retiree who is (i) covered under the 75 Point ERIP and attains age 65, or (ii) retires from the College within three months of attaining age 65, may elect between continued coverage under this Plan (100% paid by the 75 Point ERIP Retiree), where coverage under this Plan is secondary to Medicare, or a separate Medicare Supplement Plan offered by the College.

Section 5.03. Surviving Spouse Coverage.

Upon the death of an Eligible Retiree, a Surviving Spouse may elect to continue the same coverage under the Plan that was in effect at the time of the Eligible Retiree's death. Surviving Spouses are required to pay 100% of the cost of coverage for themselves and their Dependents. At age 65, a Surviving Spouse may elect between continued coverage under this Plan (100% paid by the Surviving Spouse), where coverage under this Plan is secondary to Medicare, or a separate Medicare Supplement Plan offered by the College.

Section 5.04. Enrollment Restrictions.

(a) A Covered Person who is an Eligible Retiree or Surviving Spouse may only make an election to continue coverage under the Plan pursuant to this Article V when first eligible. The Eligible Retiree or Surviving Spouse must make an election within 60 days after the later of (i) the date that the Covered Person would otherwise lose active coverage under the Plan, or (ii) the date that the Covered Person is sent an enrollment form from the College or Claims Supervisor to continue coverage under the Plan. If an election is not timely made, the Eligible Retiree or Surviving Spouse, as applicable, will be deemed to have waived all future coverage under the Plan for himself or herself and his or her Dependents.

(b) An Eligible Retiree or Surviving Spouse who timely elects coverage under this Article may enroll his or her Dependents at the same time of his or her own enrollment, or at a subsequent date in a manner consistent with the Plan's annual enrollment and special enrollment provisions under Section 4.02.

(c) An Eligible Retiree or Surviving Spouse who elects to continue coverage under this Plan may only elect into the coverage that he or she had at the time active coverage terminated. Such Eligible Retiree or Surviving Spouse may thereafter make changes to his or her coverage elections in a manner consistent with the Plan's annual enrollment and special enrollment provisions under Section 4.02.

(d) In lieu of coverage under the Plan, an Eligible Retiree, Surviving Spouse, and/or his or her Dependents may elect COBRA in accordance with Article VI. Any coverage elected under the Plan will be in lieu of any COBRA coverage to which the Eligible Retiree, Surviving Spouse, and/or his or her Dependents would otherwise be entitled.

Section 5.05. Termination of Eligible Retiree and Surviving Spouse Coverage.

(a) General. The termination provisions of this Section are subject to any exceptions provided in Article VI (COBRA).

(b) Termination of Eligible Retiree and Surviving Spouse Coverage. Coverage of an Eligible Retiree or Surviving Spouse will terminate under the Plan as of the earliest to occur of the following:

(1) The date on which the Eligible Retiree or Surviving Spouse fails to pay contributions required for coverage for Health Benefits and/or Dental Benefits or fails to make satisfactory arrangements with the College to pay such contributions.

(2) The date the Eligible Retiree or Surviving Spouse becomes a full-time member of the armed forces.

(3) The date on which the Eligible Retiree or Surviving Spouse engages in fraudulent conduct or furnishes fraudulent or misleading material information relating to claims or application for coverage with respect to Health Benefits and/or Dental Benefits.

(4) The date of the Eligible Retiree's or Surviving Spouse's death.

(5) The date on which the Plan or underlying Health Benefits or Dental Benefits terminate.

(c) Termination of Dependent Coverage. Coverage of an Eligible Employee's Dependent will terminate under the Plan as of the earliest to occur of the following

(1) The date the Eligible Retiree's coverage terminates under the Plan, other than with respect to an Eligible Retiree's Surviving Spouse.

(2) The date the Dependent no longer meets the definition of a Dependent under the Plan.

(3) The date of the Eligible Retiree's death for a Dependent Child, unless his or her Surviving Spouse is eligible for coverage and enrolls the Dependent Child;

(4) The date on which the Eligible Retiree or Surviving Spouse fails to pay contributions required for Dependent coverage for Health Benefits and/or Dental Benefits or fails to make satisfactory arrangements with the College to pay such contributions.

(5) The date of the Dependent's death.

(6) The date on which the Plan or underlying Health Benefits or Dental Benefits terminate, or, if earlier, the date the Plan discontinues Dependent coverage.

An Eligible Retiree or Surviving Spouse must notify the College immediately if a Dependent ceases to meet the eligibility requirements under the Plan. Failure to timely provide

such notice will be deemed by the College to be an act that constitutes fraud and an intentional misrepresentation of material fact prohibited by the Plan that may result in a retroactive termination of coverage. The Eligible Retiree or Surviving Spouse will be responsible for payment for any services incurred by his or her Dependent after the Dependent ceases to meet the eligibility requirements.

(d) Amendment or Termination of the Plan.

(1) The College, through action of the State Board of Trustees and the President of the College or his or her designee, will have the right, in their sole and absolute discretion, to amend or modify the Health Benefits and Dental Benefits provided to Eligible Retirees and Surviving Spouses under the Plan, and any costs associated with providing such coverage, at any time and from time to time and to any extent they may deem advisable. Such modification or amendment will be duly incorporated in writing, which will be signed by the President of the College or his or her designee.

(2) The College, through action of the State Board of Trustees and the President of the College or his or her designee, will have the right, in their sole and absolute discretion, to terminate the Health Benefits and Dental Benefits provided to Eligible Retirees and Surviving Spouses under the Plan at any time. No Eligible Retiree or Surviving Spouse is vested in the Health Benefits or Dental Benefits provided under the Plan. Termination of these provisions will be effective as determined by the College.

ARTICLE VI.
CONTINUATION OF COVERAGE

Section 6.01. Application.

(a) The Plan shall comply with all requirements under COBRA to the extent applicable, and as described in this Article.

(b) At such time that a Covered Person who is an Eligible Retiree or Surviving Spouse would otherwise lose coverage under the Plan due to his or her retirement, disability, or the death of an Eligible Retiree, respectively, he or she shall be given the opportunity to make an election to:

(1) continue coverage for himself or herself and his or her Dependents under the Plan, as set forth in Article V; or

(2) continue coverage for himself or herself and his or her Dependents under the Plan pursuant to COBRA and this Article.

An election under subparagraph (1) or (2) must be made within the 60-day election period set forth in Section 6.06. An election under subparagraph (1) will be in lieu of any COBRA coverage to which the Eligible Retiree or Surviving Spouse would be entitled to receive under this Article on the basis of the original Qualifying Event. If an Eligible Retiree or Surviving Spouse does not make a timely election under subparagraph (1) or (2), he or she shall be deemed to have waived all rights to continued coverage on behalf of himself or herself and his or her Dependents.

Section 6.02. Separately Electable Benefits.

An election for coverage under the Plan with respect to Health Benefits and Dental Benefits will each be separately electable for purposes of COBRA.

Section 6.03. Right to Continuation Coverage.

A Qualified Beneficiary may elect to continue coverage under the Plan after a Qualifying Event. Only those individuals who are covered under the Health Benefits and/or Dental Benefits on the day before the event which triggered termination of coverage (including Dependent Children born to or placed for adoption with the Qualified Beneficiary during the continuation coverage) are eligible to elect this continuation coverage.

Section 6.04. Qualified Beneficiary.

Only Qualified Beneficiaries may elect continuation coverage under the Plan. A "Qualified Beneficiary" is an individual who is a Covered Person on the day before a Qualifying Event (including Dependent Children born to or placed for adoption with the Qualified Beneficiary during the continuation coverage) who is: (i) a covered Eligible Employee or Eligible Retiree (but only with respect to Section 6.12); (ii) a Spouse of a covered Eligible Employee or Eligible Retiree (including a Surviving Spouse); or (iii) a Dependent Child of a covered Eligible Employee or Eligible Retiree.

Section 6.05. Qualifying Events.

The right to continued coverage is triggered by one of the Qualifying Events as set forth below, which, but for the continued coverage, would result in a loss of coverage under the Plan. A "loss of coverage" includes ceasing to be covered under the same terms and conditions as in effect immediately before the Qualifying Event or an increase in the premium or contribution that must be paid by a Covered Person. Qualifying Events include:

(a) the death of the covered Eligible Employee, Eligible Retiree, or Surviving Spouse;

(b) the termination (other than by reason of gross misconduct) of the covered Eligible Employee's employment, or reduction of hours of a covered Eligible Employee, that would result in a termination of coverage under the Plan;

(c) the divorce or legal separation of the covered Eligible Employee or Eligible Retiree from his or her Spouse;

(d) the covered Eligible Employee, Eligible Retiree, or Surviving Spouse becoming entitled to Medicare benefits under Title XVIII of the Social Security Act (42 USC § 1395-1395ggg);

(e) a Child of the covered Eligible Employee or Eligible Retiree ceasing to be a Dependent Child.

If any of the above-mentioned Qualifying Events occur to a Qualified Beneficiary and result in a loss of coverage, then that Qualified Beneficiary may elect to continue coverage under the Plan.

Section 6.06. Election of Continuation Coverage.

Continuation coverage does not begin unless it is elected by a Qualified Beneficiary. Each Qualified Beneficiary who loses coverage as a result of a Qualifying Event shall have an independent right to elect continuation coverage, regardless of whether any other Qualified Beneficiary with respect to the same Qualifying Event elects continuation coverage. The election period shall begin no later than the date the Qualified Beneficiary would lose coverage under the Plan due to the Qualifying Event, and shall not end before the date that is 60 days after the later of: (i) the date the Qualified Beneficiary would lose coverage due to the Qualifying Event; or (ii) the date on which notice of the right to continued coverage is sent by the Administrator or its designee. The election of continuation coverage must be made on a form provided by the Administrator or its designee and payment for coverage, as described in the notice, must be made when due. An election is considered to be made on the date it is sent to the Administrator or its designee.

Section 6.07. Period of Continuation Coverage.

(a) In the case of a Qualifying Event caused by termination of employment or reduction in hours, the Qualified Beneficiary may elect to extend coverage for a period of up to 18 months from the date of the Qualifying Event, unless it ends earlier as described under Section 6.08.

(b) If a second or additional Qualifying Event occurs during the initial 18 month continuation coverage period (or during a 29 month maximum coverage period in the case of a disability), the Qualified Beneficiary may elect to extend the continuation coverage period for a period of up to 36 months from the date of the earlier Qualifying Event. If the covered Eligible Employee became entitled to Medicare within 18 months prior to a Qualifying Event caused by termination of employment or reduction in hours, Qualified Beneficiaries (other than the covered Eligible Employee) may elect to extend coverage for a period of 36 months from the date of the covered Eligible Employee's entitlement to Medicare benefits.

(c) If a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to be disabled within 60 days of the initial continuation coverage period due to termination of employment or reduction of hours (even if the disability commenced, or was determined to be a disability before the first 60 days of the initial 18 month continuation coverage period), coverage may be continued for all Qualified Beneficiaries for a period of up to 29 months from the date of the Qualifying Event. Provided, however, notice of such disability determination must be provided by the Qualified Beneficiary to the Administrator or its designee within 18 months of the Qualifying Event and within 60 days after the latest of: (i) the date of the disability determination by the Social Security Administration; (ii) the date the Qualifying Event occurs; (iii) the date the Qualified Beneficiary loses or would lose coverage due to the Qualifying Event; or (iv) the date on which the Qualified Beneficiary is informed, via the Plan's summary plan description or the general COBRA notice, of the Qualified Beneficiary's obligation to provide such notice and procedures for providing such notice. The Qualified Beneficiary is responsible for notifying the

Administrator or its designee within 30 days of the later of: (i) the date of the final determination by the Social Security Administration that the Qualified Beneficiary is no longer disabled; or (ii) on the date which the Qualified Beneficiary is informed, via the Plan's summary plan description or the general COBRA notice, of his or her obligation to provide such notice and procedures for providing such notice.

(d) In the case of any Qualifying Event not otherwise described in subsections (a), (b), and (c), the Qualified Beneficiary may elect to extend coverage for a period of up to 36 months from the date of the Qualifying Event, unless it ends earlier as described under Section 6.08.

Section 6.08. End of Continuation Coverage.

Continuation coverage shall end earlier than the period specified under Section 6.07 as of the date on which:

(a) Timely payment of premiums for the continuation coverage is not made (including any grace periods);

(b) The Qualified Beneficiary first becomes covered under any other group health plan, after the date on which continuation coverage is elected, as an employee or otherwise, unless such other plan contains a limitation (other than a limitation which does not apply by virtue of HIPAA with respect to any pre-existing condition of the Qualified Beneficiary);

(c) The Qualified Beneficiary first becomes entitled to benefits under Medicare, after the date on which continuation coverage is elected;

(d) The College ceases to provide any group health plan to any Employee; or

(e) The Qualified Beneficiary ceases to be disabled, if continuation coverage is due to the disability.

Notwithstanding the foregoing, the Plan may also terminate the continuation coverage of a Qualified Beneficiary for cause on the same basis that the Plan could terminate the coverage of a similarly situated non-COBRA beneficiary for cause (*e.g.*, in the case of submitting fraudulent claims to the Plan).

Section 6.09. Cost of Continuation Coverage.

The Qualified Beneficiary is responsible for paying the cost of continuation coverage, hereinafter referred to as the "premium." The premiums are payable on a monthly basis, and shall not exceed 102% of the full premium cost for such coverage (or 150% in the event of a disability). After a Qualifying Event, the Administrator (or its designee) shall provide a notice specifying the amount of the premium, to whom the premium is to be paid, and the date of each month payment is due. Failure to pay premiums on a timely basis shall result in termination of coverage as of the date the premium is due. Payment of any premium, other than that referred to below, shall only be considered to be timely if made within 30 days after the date due. A premium must be paid for the cost of continuation coverage for the time period between the date of the event which triggered continuation coverage and the date continued coverage is elected. This payment must be made

within 45 days after the date of election. The Administrator (or its designee) shall provide notice specifying the amount of the premium, to whom the premium is to be paid, and the date payment is due. Failure to pay this premium on the date due shall result in cancellation of coverage back to the initial date coverage would have terminated.

Section 6.10. Notification Requirements.

(a) General Notice to Qualified Beneficiary. The Plan shall provide, at the time of commencement of coverage, written notice to each covered Eligible Employee and Eligible Retiree, and his or her Spouse (if any) of their rights to continuation coverage. The Plan may satisfy this obligation by furnishing a single notice addressed to both a covered Eligible Employee or Eligible Retiree and his or her Spouse if they both reside at the same address, and the Spouse's coverage commences on or after the date on which the covered Eligible Employee's or Eligible Retiree's coverage commences, but not later than the date by which this general notice must be provided under this subsection (a). No separate notice is required to be sent to Dependent Children who share a residence with a covered Eligible Employee or Eligible Retiree, or his or her Spouse. This general notice shall be provided not later than the earlier of: (i) 90 days after such individual's coverage commencement date under the Plan or (ii) the date on which the Administrator is required to furnish a COBRA election notice as described in paragraph (d).

(b) College Notice to Administrator. The College shall notify the Administrator or its designee in the event of (i) a covered Eligible Employee's death, termination of employment (other than gross misconduct), reduction in hours, or entitlement to Medicare benefits, or (ii) a covered Eligible Retiree's death within 30 days after the date of the Qualifying Event.

(c) Qualified Beneficiary Notice to Administrator. The appropriate Qualified Beneficiary in the following situations must notify the Administrator or its designee of:

(1) a divorce or legal separation of the covered Eligible Employee or Eligible Retiree from his or her Spouse;

(2) a Child ceasing to be a Dependent Child;

(3) a second Qualifying Event;

(4) notice of disability entitlement or cessation of disability.

Notification must occur as soon as possible, and for events under (1) through (3) above, such notice must occur no later than 60 days after the later of: (i) the date of such Qualifying Event; (ii) the date that the Qualified Beneficiary loses or would lose coverage due to such Qualifying Event, or (iii) the date on which the Qualified Beneficiary is informed, via the Plan's summary plan description or the general COBRA notice, of the Qualified Beneficiary's obligation to provide such notice and the Plan procedures for providing such notice. See Section 6.07 for timing of notices applicable to disability determinations.

The covered Eligible Employee, Eligible Retiree, Qualified Beneficiary, or his or her representative, may provide such notice. The provisions of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to

the Qualifying Event. Failure to provide such timely notice shall result in the loss of any right to elect continuation coverage.

The Plan shall establish reasonable procedures for the furnishing of the notice described above that comply with 29 CFR § 2590.606-3. A Qualified Beneficiary's failure to follow such procedures within the times prescribed above shall result in a denial of continuation coverage.

(d) Administrator Notice to Qualified Beneficiary. Upon receipt of a notice of a Qualifying Event under paragraph (b) or (c), the Administrator or its designee shall provide to each Qualified Beneficiary notice of his or her right to elect continuation coverage no later than 14 days after the date on which the Administrator or its designee received notice of the Qualifying Event. Any notification to a Qualified Beneficiary who is the Spouse of the covered Eligible Employee or Eligible Retiree shall be treated as a notification to all other Qualified Beneficiaries residing with such Spouse at the time such notification is made.

(e) Unavailability of Coverage. If the Administrator or its designee receives a notice of an applicable Qualifying Event or disability determination under paragraph (b) or (c) and determines that the person is not entitled to continuation coverage, the Administrator or its designee shall notify the person with an explanation as to why such coverage is not available within the time frame designated under paragraph (d) above.

(f) Notice of Termination of Coverage. The Administrator or its designee shall provide notice to each Qualified Beneficiary of any termination of continuation coverage which is effective earlier than the end of the maximum period of continuation coverage applicable to such Qualifying Event, as soon as practicable following the Administrator's determination that continuation coverage should terminate.

(g) Use of a Single Notice. Notices required under paragraphs (d), (e) and (f) must be provided to each Qualified Beneficiary or individual, provided that a single notice can be provided to the covered Eligible Employee or Eligible Retiree and his or her Spouse if they both reside at the same address, and a single notice can be provided to the covered Eligible Employee or Eligible Retiree or his or her Spouse for a Dependent Child who resides at the same address.

Section 6.11. Continuation Benefits Provided.

The continuation coverage provided to a Qualified Beneficiary who elects continued coverage shall be identical to the coverage provided under the Plan to similarly situated persons covered by the Plan with respect to whom a Qualifying Event has not occurred. If coverage is modified under the Plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are Qualified Beneficiaries under the Plan. Continuation coverage may not be conditioned on evidence of good health.

If the Plan provides an open enrollment period during which similarly situated active employees may choose to be covered under another group health plan or under another benefit package within the Plan, or to add or eliminate coverage of family members, the Plan shall provide the same opportunity to Qualified Beneficiaries who have elected continuation coverage.

Section 6.12. Bankruptcy Proceedings.

Special continuation coverage provisions apply in the event of bankruptcy of the College. Notwithstanding any of the preceding Sections, in the event of a bankruptcy proceeding under Title XI of the United States Code, where a loss of coverage or substantial elimination of coverage occurs with respect to a covered Eligible Retiree who had retired on or before the date of the loss or substantial elimination of coverage (and any other individual who, on the day before the bankruptcy proceeding, is a beneficiary under the Plan as a Spouse, Dependent Child, or Surviving Spouse within one year before or after the date of the commencement of the bankruptcy proceeding), continuation coverage shall be provided under the Plan to the extent required under Code Section 4980(B).

ARTICLE VII.
FAMILY AND MEDICAL LEAVE ACT

Section 7.01. Application.

The Plan shall provide continuation coverage consistent with the provisions of the FMLA and any applicable collective bargaining agreements.

Section 7.02. Coverage During FMLA Leaves.

(a) The FMLA generally allows certain employees who have worked at least 1,250 hours during the preceding 12 months the right to take an unpaid leave (or a paid leave if it has been earned) for a period of up to 12 work weeks during a 12 month period because of (i) the birth of a child and to care for such child, (ii) the placement of a child for adoption or foster care, and to care for such child, (iii) the need to care for a family member (child, spouse, or parent) with a "serious health condition" as defined under the FMLA, (iv) an employee's own "serious health condition" that makes the employee unable to do his or her job, or (v) any "qualifying exigency" (as defined under the FMLA) arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation. For purposes of FMLA, the term "spouse" means a husband or wife as defined or recognized under state law for purposes of marriage in the state where the employee resides.

(b) In addition, any spouse, son, daughter, parent, or nearest blood relative ("next of kin") of a "covered service member" shall be granted leave not to exceed a total of 26 work weeks during a single 12 month period to care for the "covered service member." During the single 12 month period described above, an Eligible Employee may be granted a combined total of 26 work weeks of leave for any combination of leaves under the FMLA. For purposes of this policy, the phrase "covered service member" means a member of the Armed Forces, including a member of the National Guard or Reserves, who: (i) is undergoing medical treatment, recuperation, or therapy; (ii) is otherwise in an "outpatient status" (as defined by regulations); or (iii) is otherwise on the temporary disability retired list for a "serious injury or illness" (as defined by regulations).

(c) Notwithstanding any other provisions in the Plan to the contrary, under the FMLA, an Eligible Employee who is covered under the Plan is entitled to continue Health Benefits and

Dental Benefits during the period the Eligible Employee is on a FMLA leave. If paid leave runs concurrently with FMLA leave, employee contributions must be made by payroll deduction. If the FMLA leave is unpaid leave, employee contributions must be paid at the same time as the contribution would be made if by payroll deduction, or as otherwise agreed to in writing between the College and the Eligible Employee. Failure of an Eligible Employee to pay his or her share of contributions within 30 days after the due date may result in termination of coverage, subject to this Article. The Health Benefits and Dental Benefits provided pursuant to the FMLA under the Plan are the same benefits that would be provided if the Eligible Employee had been employed during the leave period. The Eligible Employee may choose not to continue Health Benefits and Dental Benefits under the Plan during the FMLA leave. If the Eligible Employee chooses to discontinue coverage during the FMLA leave (or if coverage ends due to the failure to make timely contributions), the Eligible Employee shall be immediately reinstated in Health Benefits and/or Dental Benefits, as applicable, when the Eligible Employee returns from the FMLA leave without regard to any waiting period.

(d) Except as provided under Article VI, FMLA benefit coverage shall terminate when:

(1) the Eligible Employee informs the College of his or her intent not to return from FMLA leave;

(2) the Eligible Employee fails to return from the FMLA leave; or

(3) the Eligible Employee exhausts his or her FMLA leave.

(e) Eligible Employees shall pay any applicable employee contributions in accordance with the Plan.

(f) The College may recover the following payments from the Eligible Employee:

(1) Contributions made by the College during a period of unpaid FMLA leave for maintaining the Health Benefits and/or Dental Benefits if the Eligible Employee fails to return to work after the FMLA leave has been exhausted, unless the failure to return to work is due to a serious health condition of the Eligible Employee or a family member or other circumstances beyond the Eligible Employee's control.

(2) The Eligible Employee's share of contributions the Eligible Employee was obligated to make but which the College elected to make on the Eligible Employee's behalf in order to maintain the Eligible Employee's Health Benefits and/or Dental Benefits, regardless of whether the Eligible Employee returns from such leave.

ARTICLE VIII.
FEDERAL REQUIREMENTS

Section 8.01. Health Insurance Portability and Accountability Act of 1996.

The Health Benefits provided under the Plan shall comply with HIPAA, as amended from time to time, and any regulations issued thereunder. As part of such compliance, the Health Benefits will be administered to (i) allow special enrollment periods as provided in the Plan, (ii)

prohibit pre-existing condition exclusions, and (iii) prohibit discrimination against any individual on the basis of a health status related factor, as that term is defined in HIPAA.

Section 8.02. Genetic Information Nondiscrimination Act of 2008.

The Health Benefits provided under the Plan shall comply with the Genetic Information Nondiscrimination Act of 2008, as amended, and any regulations issued thereunder. As part of such compliance, the Plan shall not adjust premiums or contribution amounts on the basis of genetic information, and shall not request or require an individual or a family member of such individual to undergo a genetic test unless the research exception under Code Section 9802(c)(4) is satisfied. The Plan also shall not request, require, or purchase genetic information for underwriting purposes or with respect to any individual prior to such individual's enrollment in Health Benefits, or in connection with such enrollment.

Section 8.03. Mental Health Parity Act of 1996.

The Health Benefits provided under the Plan shall comply with the Mental Health Parity Act of 1996 and the Mental Health Parity and Addiction Equity Act of 2008, both as amended, and any regulations issued thereunder. As part of such compliance, the financial requirements and treatment limitations applicable to coverage for mental health and substance use disorder benefits will be no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all coverage for medical and surgical benefits, determined pursuant to these Acts.

Section 8.04. Newborns' and Mothers' Health Protection Act of 1996.

The Health Benefits provided under the Plan shall comply with the Newborns' and Mothers' Health Protection Act of 1996, as amended, and any regulations issued thereunder. As part of such compliance, the Health Benefits shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following normal vaginal delivery, or less than 96 hours following a caesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

Section 8.05. Women's Health and Cancer Rights Act of 1998.

The Health Benefits provided under the Plan shall comply with the Women's Health and Cancer Rights Act of 1998, as amended, and any regulations issued thereunder. As part of such compliance, if a Covered Person is receiving Health Benefits in connection with a mastectomy and elects breast reconstruction in connection with such mastectomy, the Plan shall cover in a manner determined in consultation with the attending physician and the Covered Person (i) reconstruction of the breast on which the mastectomy has been or will be performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, (iii) prostheses, and (iv) physical complications at all states of the mastectomy, including lymphedemas. These benefits will be provided subject to the same deductibles and coinsurance applicable to other Health Benefits provided under the Plan.

Section 8.06. Eligibility for Medicaid Benefits.

Benefits shall be paid in accordance with any assignment of rights made by or on behalf of any Covered Person as required by a state plan for medical assistance approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act. For purposes of enrollment and entitlement to benefits, a Covered Person's eligibility for or receipt of medical benefits under a state plan for medical assistance approved under Title XIX of the Social Security Act shall not be taken into account. The state shall have a right to any payment made under a state plan for medical assistance approved under Title XIX of the Social Security Act when the Plan has a legal liability to make such payment.

Section 8.07. Dependent Students on Medically Necessary Leave of Absence.

The Health Benefits provided under the Plan shall comply with Michelle's Law of 2008, as amended, and any regulations issued thereunder. As part of such compliance, the Plan will extend coverage to Dependent students while on medically necessary leaves of absence pursuant to the requirements of Michelle's Law.

Section 8.08. Patient Protection and Affordable Care Act of 2010.

The Health Benefits provided under the Plan shall comply with the Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act"), as amended, and any regulations issued thereunder. As part of such compliance, the Health Benefits will be administered to (i) provide coverage to Dependent Children until age 26 regardless of marital status or any other dependency factor; (ii) not impose lifetime or annual dollar limits on essential health benefits; (iii) not impose pre-existing condition exclusions; (iv) provide preventive care services with no cost-sharing requirements from network providers; (v) provide an internal claims and appeals process and External Review process that meets the requirements under the Affordable Care Act; (vi) prohibit Rescissions except in the case of fraud or an intentional misrepresentation of material fact; (vii) provide coverage of clinical trials as required under the Affordable Care Act; (viii) limit waiting periods to 90 or less days; and (ix) comply with any other change required by the Affordable Care Act.

ARTICLE IX.
PROTECTED HEALTH INFORMATION

Section 9.01. Adoption and Effective Date.

This Article is adopted to reflect certain provisions of HIPAA. It is intended as good faith compliance with the requirements of HIPAA and is to be construed in accordance with HIPAA and guidance issued thereunder. The Plan shall comply with all requirements under this Article to the extent applicable, as described below.

Section 9.02. Supersession of Inconsistent Provisions.

This Article shall supersede the provisions of the Plan to the extent those provisions are inconsistent with the provisions of this Article.

Section 9.03. Use and Disclosure of Protected Health Information.

The Plan shall use and disclose Protected Health Information to the extent of and in accordance with the uses and disclosures permitted by HIPAA, as set forth in the Privacy Regulations. Specifically, the Plan shall use and disclose Protected Health Information for purposes related to health care treatment, Payment for health care, and Health Care Operations.

Section 9.04. Plan Documents.

In order for the Plan to disclose Protected Health Information to the College or to provide for or permit the disclosure of Protected Health Information to the College by a health insurance issuer or HMO with respect to the Plan, the Plan must ensure that the Plan documents restrict uses and disclosures of such information by the College consistent with the requirements of HIPAA.

Section 9.05. Disclosures by Plan to the College.

The Plan may or may not make the following disclosures to the Plan, as provided below:

(a) The Plan may disclose Summary Health Information to the College, if the College requests the Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan; or modifying, amending, or terminating the Plan.

(b) The Plan may disclose to the College information on whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer offered by the Plan.

(c) The Plan may disclose Protected Health Information to the College to carry out Plan administration functions that the College performs, consistent with the provisions of Sections 9.06 through 9.08.

(d) With an authorization from the Covered Person, the Plan may disclose Protected Health Information to the College for purposes related to the administration of other employee benefit plans and fringe benefits sponsored by the College.

(e) The Plan may not permit a health insurance issuer with respect to the Plan to disclose Protected Health Information to the College except as permitted by this Section.

(f) The Plan may not disclose (and may not permit a health insurance issuer to disclose) Protected Health Information to the College as otherwise permitted by this Section unless a statement is included in the Plan's notice of privacy practices that the Plan (or a health insurance issuer with respect to the Plan) may disclose Protected Health Information to the College.

(g) The Plan may not disclose Protected Health Information to the College for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the College.

(h) The Plan may not disclose (and may not permit a health insurance issuer to disclose) Protected Health Information that is genetic information about an individual for underwriting purposes as defined in Section 1180(b)(4) of the Social Security Act and underlying regulations.

Section 9.06. Uses and Disclosures by the College.

The College may only use and disclose Protected Health Information as permitted and required by the Plan, as set forth within this Article. Such permitted and required uses and disclosures may not be inconsistent with the provisions of HIPAA. The College may use and disclose Protected Health Information without an authorization from an Eligible Employee or Eligible Retiree for Plan administrative functions including Payment activities and Health Care Operations. In addition, the College may also use and disclose Protected Health Information to accomplish the purpose for which any disclosure is properly made pursuant to Section 9.05.

Section 9.07. Certification.

The Plan may disclose Protected Health Information to the College only upon receipt of a certification from the College that the Plan documents have been amended to incorporate the provisions provided for in this Section and that the College so agrees to the provisions set forth therein.

Section 9.08. Conditions Agreed to by the College.

The College agrees to the following conditions:

(a) The College will not use or further disclose Protected Health Information other than as permitted or required by the Plan document or as required by law.

(b) The College will ensure that any agents, including a subcontractor, to whom the College provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the College with respect to such Protected Health Information, and that any such agents or subcontractors agree to implement reasonable and appropriate security measures to protect any Electronic Protected Information belonging to the Plan that is provided by the College.

(c) The College will not use or disclose Protected Health Information for employment-related actions and decisions unless authorized by an Individual.

(d) The College will not use or disclose Protected Health Information in connection with any other benefit or employee benefit plan of the College unless authorized by an Individual.

(e) The College will report to the Plan any Protected Health Information use or disclosure that is inconsistent with the uses or disclosures provided for by this Article, or any Security Incident of which it becomes aware.

(f) The College will make Protected Health Information available to an Individual in accordance with HIPAA's access requirements pursuant to 45 CFR § 164.524.

(g) The College will make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR § 164.526.

(h) The College will make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.

(i) The College will make internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA.

(j) If feasible, the College will return or destroy all Protected Health Information received from the Plan that the College still maintains in any form, and retain no copies of such Protected Health Information when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

(k) The College will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates receives, maintains, or transmits on behalf of the Plan.

(l) The College will ensure that the separation and requirements of Sections 9.09, 8.10, and 8.11 of the Plan are supported by reasonable and appropriate security measures.

Section 9.09. Adequate Separation Between the Plan and the College.

In accordance with HIPAA, only the designated Privacy Officer and those individuals identified in the HIPAA Policies and Procedures who have a need for Protected Health Information to help administer the Plan may be given access to Protected Health Information.

Section 9.10. Limitations of Access and Disclosure.

The persons described in Section 9.09 may only have access to and use and disclose Protected Health Information for Plan administration functions that the College performs for the Plan.

Section 9.11. Noncompliance.

If the persons or classes of persons described in Section 8.09 of this Article do not comply with this Plan document, the Plan and the College shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

ARTICLE X.
USERRA RIGHTS AND COVERAGE

Section 10.01. Application.

The Plan shall comply with all requirements under the USERRA to the extent applicable, and as described below.

Section 10.02. USERRA Continuation Coverage.

(a) An Eligible Employee may be entitled to reemployment and other rights during and after a period of Service in the Uniformed Services under USERRA, including certain contributions and service credits under the Plan that are subject to USERRA. The Plan shall be administered in compliance with the requirements of USERRA to the extent applicable.

(b) To be eligible for such USERRA benefits, before leaving for military service, the Eligible Employee is generally required to give the College advance notice that such Eligible Employee is leaving the job for Service in the Uniformed Services. When such Eligible Employee returns from military service, he or she must timely submit an application for reemployment with the College and request information regarding his or her reemployment rights. Time limits for returning to work shall depend on the length of time of such military service.

Section 10.03. Continuation of Coverage.

Subject to the terms and conditions of any applicable collective bargaining agreement, if an Eligible Employee is absent from a position of employment with the College by reason of Service in the Uniformed Services and was enrolled in Health Benefits and/or Dental Benefits immediately prior to his or her absence due to Service in the Uniformed Services, the Eligible Employee shall be entitled to elect to continue such coverage for the Eligible Employee and his or her covered Dependents for the time period allowed under the Plan. Thereafter, coverage will continue for a period equal to the lesser of (i) the 24 month period beginning on the date on which such Eligible Employee is absent from employment with the College by reason of Service in the Uniformed Services or (ii) the day following the date on which the Eligible Employee fails to apply for or return to a position of employment with the College as determined pursuant to USERRA Section 4312(e). Eligible Employees may elect to discontinue coverage under the Plan during Service in the Uniformed Services by submitting the applicable forms to the College.

Section 10.04. Election of USERRA Continuation Coverage.

(a) Continuation coverage does not begin unless it is elected by the Eligible Employee.

(b) The Eligible Employee may elect to continue coverage by reason of Service in the Uniformed Services for himself or herself and his or her covered Dependents. Dependents do not have an independent right to elect USERRA continuation coverage. The election period for continued coverage shall begin on the date the Eligible Employee gives the College advance notice that he or she is required to report for Uniformed Service (whether such service is voluntary or involuntary) and shall end 60 days after the date the Eligible Employee would otherwise lose coverage under the Plan.

(c) If the Eligible Employee is unable to give advance notice of Uniformed Service, the Eligible Employee may still be able to elect continuation coverage under this Article if the failure to give advance notice was because giving such notice was impossible, unreasonable, or precluded by military necessity. In such a case, the election period shall begin on the date the Eligible Employee leaves for Uniformed Service and shall end on the earlier of: (i) the 24 month period beginning on the date on which the Eligible Employee's absence for the Uniformed Service begins; or (ii) the date on which the Eligible Employee fails to return from Uniformed Service or apply for a position of employment as provided under 20 CFR §§ 1002.115-123. For these purposes, "military necessity" occurs only when deemed to be so by a designated military authority as described in 20 CFR § 1002.86 and may include situations where a mission, operation, exercise or requirement is classified, or could be compromised or otherwise adversely affected by public knowledge. It may be impossible or unreasonable to give advance notice under certain circumstances such as when the appropriate representative of the College is unavailable or the Eligible Employee is required to report for Uniformed Service in an extremely short period of time.

(d) The election of USERRA continuation coverage must be made on a form provided by the Administrator and made within the 60 day period described herein. An election is considered to be made on the date it is sent to the Administrator. If timely elected pursuant to this Section, coverage shall be reinstated as of the date the Eligible Employee lost coverage due to absence for Service in the Uniformed Service and shall last for the period set forth in Section 10.03; provided that the Eligible Employee pays all unpaid costs for the coverage pursuant to Section 10.05.

Section 10.05. Cost of USERRA Continuation Coverage.

(a) If an Eligible Employee elects continuation coverage pursuant to Section 10.04, the Eligible Employee will be required to pay 102% of the full premium cost for such coverage; provided, however, if the Eligible Employee's Service in the Uniformed Services is for a period of fewer than 31 days, he or she will not be required to pay more for such coverage than is otherwise required for active Eligible Employees.

(b) Premiums are due on the first day of each month for which continuation coverage is desired. Failure to pay premiums on a timely basis shall result in termination of coverage as of the date the premium is due. Payment of any premium, other than that referred to below, shall only be considered to be timely if made within 30 days after the date due. A premium must also be paid for the cost of continuation coverage for the time period between the date that continuation coverage commences and the date continuation coverage is elected. This payment must be made within 45 days after the date of election. Failure to pay this premium on the date due shall result in cancellation of coverage back to the initial date coverage would have terminated.

Section 10.06. Coordination with COBRA.

An Eligible Employee who is absent from work by reason of Service in the Uniformed Services may be eligible for continuation coverage under Article VI. The continuation coverage provided in this Article shall not limit or otherwise interfere with those continuation coverage

rights detailed in Article VI; provided, however, any continuation coverage provided under this Article shall run concurrently with any continuation coverage available under Article VI.

Section 10.07. USERRA Continuation Health Benefits Provided.

The continuation coverage provided to an Eligible Employee serving in the Uniformed Services who elects continued coverage for himself or herself (and his or covered Dependents) shall be identical to the coverage provided under the Plan to similarly situated persons covered by the Plan who are active. If coverage is modified under the Plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are covered under USERRA continuation coverage. Continuation coverage may not be conditioned on evidence of good health. If the Plan provides an open enrollment period during which similarly situated active employees may choose to be covered under another group health plan or under another benefit package within the Plan, or to add or eliminate coverage of family members, the Plan shall provide the same opportunity to individuals who have elected USERRA continuation coverage.

Section 10.08. Waiting Period and Exclusions Upon Reemployment.

Notwithstanding any other provision herein, an Eligible Employee and his or her eligible covered Dependents whose benefit coverage is terminated by reason of Service in the Uniformed Services shall not be subject to any exclusion or waiting period upon reinstatement of such coverage under the Plan following Service in the Uniformed Services; provided, however, the above shall not apply to any condition determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during the performance of Service in the Uniformed Services.

Section 10.09. Reinstatement of Coverage Upon Reemployment.

The College shall promptly reinstate an Eligible Employee's Health Benefits and/or Dental Benefits coverage at reemployment upon request, consistent with the terms of the Plan.

Section 10.10. Rights, Benefits, and Obligations of Employees Absent from Employment by Reason of Service in the Uniformed Services.

An Eligible Employee who is absent from employment with the College by reason of Service in the Uniformed Services shall be considered on furlough or leave of absence while performing such service and shall be entitled to such other rights and benefits as are generally provided by the College to Employees having similar status and pay who are on furlough or leave of absence; provided, however, an Eligible Employee who knowingly provides written notice of intent not to return to employment with the College shall cease to be entitled to such rights and benefits. Furthermore, an Eligible Employee who is absent from employment with the College by reason of Service in the Uniformed Services shall be permitted to apply any accrued paid vacation, annual or similar leave while on such leave by reason of Service in the Uniformed Services.

ARTICLE XI.
FUNDING POLICY AND CONTRIBUTIONS TO THE PLAN

The College shall be responsible for establishing and carrying out the funding policy of the Plan for the provisions of benefits consistent with the objectives of the Plan. Uninsured benefits adopted by the College may be paid from the general assets of the College. Contributions to provide fully insured benefits or self-insured benefits under the Plan shall be paid to the appropriate insurance company or benefit provider pursuant to the Health Benefits and Dental Benefits maintained by the College. Contributions may consist of contributions paid by the College or by the Eligible Employee, Eligible Retiree, or Surviving Spouse, as applicable. The College shall determine the amount, if any, of contributions to be made by each Eligible Employee, Eligible Retiree, or Surviving Spouse for Health Benefits and Dental Benefits, which amounts shall be communicated to each such individual. Certain contributions made by Eligible Employees through salary reduction shall be treated as contributions made by the College, consistent with the Flexible Benefit Plan.

ARTICLE XII.
ADMINISTRATION OF THE PLAN

Section 12.01. Administrator.

The College shall be the Administrator of the Plan; provided, however, the Administrator may from time to time designate a person, committee, Claims Supervisor, or organization to perform certain responsibilities of the Administrator. Any such individual, committee, Claims Supervisor, or organization shall perform the delegated functions until removal by the Administrator, which removal may be without cause and without advance notice. Except as otherwise specifically provided in the Plan, the Administrator shall have full, discretionary authority to control and manage the operation and administration of the Plan, and shall be named fiduciary of the Plan. The Administrator shall have all power necessary or convenient to enable the Administrator to exercise such authority. The Administrator or its designee may provide rules and regulations, not inconsistent with the provisions hereof, for the operation and management of the Plan, and may from time to time amend or rescind such rules or regulations. The Administrator shall have the full discretion, power, and the duty to take all action necessary or proper to carry out the duties required under the Plan. The Administrator is authorized to accept service of legal process for the Plan.

Section 12.02. Claims Supervisor.

The College may appoint or remove a Claims Supervisor with respect to the Health Benefits and Dental Benefits provided under the Plan.

Section 12.03. Discretionary Authority of Administrator.

Except as may be otherwise specifically provided in the Plan, the Administrator or its designee shall have full, discretionary authority to enable it to carry out its duties under the Plan, including, but not limited to, the authority to determine eligibility under the Plan and to construe the terms of the Plan and to determine all questions of fact or law arising hereunder. The

Administrator or its designee shall have all power necessary or convenient to enable the Administrator to exercise such authority. The Administrator or its designee shall have full, discretionary authority to correct any defect, supply any omission or reconcile any inconsistency and resolve ambiguities in the Plan in such manner and to such extent as it may deem expedient, and the Administrator or its designee shall be the sole and final judge of such expediency. Subject to Article XIII, all such determinations and interpretations shall be final, conclusive, and binding on all persons affected thereby, and benefits under the Plan shall be paid only if the Administrator and/or its designee decides in its discretion that a Covered Person is entitled to such benefits.

ARTICLE XIII.
CLAIMS PROCEDURES

Section 13.01. Application.

(a) The following procedures shall apply to the extent that the written documents describing the Health Benefits and/or the Dental Benefits, as incorporated under Schedule B, either do not contain specific claims procedures or such claim procedures do not comply with the requirements under the Patient Protection and Affordable Care Act (with respect to Health Benefits only).

(b) Subject to paragraph (a), Section 13.02 shall apply to the internal claims procedure applicable to Health Benefits and Dental Benefits, and Section 13.03 shall apply to the External Review process available with respect to eligible Health Benefits claims. All notifications by any Claims Supervisor to a Claimant for claim review, Denial, approval and Appeal may be done in writing or electronically, unless otherwise designated.

Section 13.02. Internal Review of Claims.

(a) Initial Claim. Any claim to receive benefits under the Plan must be filed with the Claims Supervisor within the designated time period on the designated form, and will be deemed filed upon receipt. If a Claimant fails to follow the claims procedures outlined herein for filing an Urgent Care Claim or a Pre-Service Claim, the Claimant will be notified orally (unless the Claimant requests written notice) of the proper procedures to follow, not later than 24 hours for Urgent Care Claims and five days for Pre-Service Claims. This special timing rule applies only to Urgent Care Claims and Pre-Service Claims that are received by the person or unit customarily responsible for handling benefit matters and specify a Claimant, a medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

(b) Initial Review of Claim. When a claim for benefits has been properly filed, the Claimant will be notified of the approval or Denial within the time periods set forth in the chart under paragraph (k) below. For Urgent Care Claims, the Claims Supervisor will defer to the attending provider with respect to the decision as to whether a claim is an Urgent Care Claim for purposes of determining the applicable time period.

(c) Initial Denial of Claim. If any claim for benefits is partially or wholly Denied, the Claimant will be given notice which will contain the following items:

(1) the specific reasons for the Denial;

(2) references to applicable Plan provisions upon which the Denial is based;

(3) a description of any additional material or information needed and why such material or information is necessary;

(4) a description of the review procedures and time limits, including information regarding how to initiate an Appeal, and information on the External Review process (with respect to Health Benefits);

(5) the specific internal rule, guideline, protocol, or other similar criterion, if any, relied upon in making the Denial, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon, with a copy free of charge upon request;

(6) if the Denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request;

(7) for Urgent Care Claims, a description of the expedited review process applicable to such claims; and

(8) for Denials of Health Benefits, (A) information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning), (B) the Denial code and its corresponding meaning, as well as a description of the Claims Supervisor's standard, if any, that was used in the Denial of the claim, and (C) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist individuals with the internal claims and Appeals and External Review processes.

For Urgent Care Claims, the information in the notice may be provided orally if the Claimant is given notification within three days after the oral notification.

(d) Appeal of Claim Denial. A Claimant may initiate an Appeal of the Denial of a benefit claim by filing a written claim Appeal with the Claims Supervisor within the time period set forth in paragraph (k), which will be deemed filed upon receipt. If the request is not timely, the decision of the Claims Supervisor will be the final decision of the Plan, and will be final, conclusive, and binding on all persons. For Urgent Care Claims, a Claimant may make a request for an expedited Appeal orally or in writing, and all necessary information will be transmitted by telephone, facsimile, or other similarly expeditious method.

(e) Decision on Appeal.

(1) The Claimant will receive notice of the Claims Supervisor's decision on Appeal within the time periods shown in paragraph (k).

(2) With respect to claims for Health Benefits, the Claims Supervisor will provide the Claimant with the following information free of charge as soon as possible and sufficiently in advance of the date on which the notice of Final Denial is required under paragraph (k), such that the Claimant has a reasonable opportunity to respond prior to that date: (A) any new or additional evidence considered, relied upon, or generated by the Claims Supervisor (or at the direction of the Claims Supervisor) in connection with the claim, and (B) any new or additional rationale that forms the basis of the Claims Supervisor's Final Denial, if any.

(3) If the claim is denied on Appeal (including a Final Denial), the Claimant will be given notice with a statement that the Claimant is entitled to receive, free of charge, access to and copies of all documents, records, and other information that apply to the claim. The notice will also contain:

(A) the specific reasons for the Denial;

(B) references to applicable Plan provisions upon which the Denial is based;

(C) a description of the review procedures and time limits, including information on the External Review process (with respect to Health Benefits);

(D) the specific internal rule, guideline, protocol, or other similar criterion, if any, relied upon in making the Denial, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon, with a copy free of charge upon request;

(E) if the Denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request;

(F) for Denials of Health Benefits, (i) information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning), (ii) the Denial code and its corresponding meaning, as well as a description of the Claims Supervisor's standard, if any, that was used in the Denial of the claim, and (iii) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist individuals with the internal claims and Appeals and External Review process; and

(G) for Denials of Health Benefits, a discussion of the decision; and

(4) Except as provided in Section 13.03 below with respect to the External Review process for eligible Health Benefits claims, the decision on Appeal will be final, conclusive, and binding on all persons.

(f) Ongoing Treatments.

(1) If the Claims Supervisor or Administrator, as appropriate, under the Plan has approved an ongoing course of treatment to be provided to a Claimant over a certain period of time or for a certain number of treatments, any reduction or termination under of such course of treatment before the approved period of time or number of treatments end will constitute a Denial. The Claimant will be notified of the Denial in accordance with the provisions of this Section 13.02 before the reduction or termination occurs to allow the Claimant a reasonable time to file an Appeal and obtain a determination on the Appeal. With respect to Appeals for Health Benefits, coverage for the ongoing course of treatment that is the subject of the Appeal will continue pending the outcome of such Appeal.

(2) For an Urgent Care Claim, any request by a Claimant to extend the ongoing treatment beyond the previously approved period of time or number of treatments will be decided no later than 24 hours after receipt of the Urgent Care Claim, provided the claim is filed at least 24 hours before the treatment expires.

(g) Authorized Representative. The Plan shall not prevent an authorized representative of a Claimant from acting on behalf of the Claimant in pursuing a benefit claim or Appeal, pursuant to reasonable procedures. In the case of an Urgent Care Claim, a health care professional with knowledge of a Claimant's medical condition shall be permitted to act as the authorized representative of the Claimant.

(h) Calculating Time Periods. The period of time within which an initial benefit determination or a determination on an Appeal is required to be made will begin when a claim or Appeal is filed regardless of whether the information necessary to make a determination accompanies the filing. Solely for purposes of initial Pre-Service Claims and Post-Service Claims, if the time period for making the initial benefit determination is extended (in the Claims Supervisor's discretion) because the Claimant failed to submit information necessary to decide the claim, the time period for making the determination will be suspended from the date notification of the extension is sent to the Claimant until the earlier of (1) the date on which response from the Claimant is received, or (2) the end of the time period given to the Claimant to provide the additional information (at least 45 days).

(i) Full and Fair Review.

(1) Upon request and free of charge, the Claimant or his or her duly authorized representative will be given reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim, or may submit to the appropriate person or entity written comments, documents, records, and other information relating to the claim. If timely requested, review of a Denied claim will take into account all

comments, documents, records, and other information submitted by the Claimant or his or her duly authorized representative relating to his or her claim without regard to whether such information was submitted or considered in the initial benefit determination.

(2) Appeals will be reviewed by an appropriate named fiduciary of the Plan who is neither the individual nor subordinate of the individual who made the initial determination. The Claims Supervisor will not give any weight to the initial determination, and, if the Appeal is based, in whole or in part, on a medical judgment, the Claims Supervisor will consult with an appropriate health care professional who is neither the individual nor subordinate of the individual who was consulted in connection with the initial determination. The Claims Supervisor will identify any medical or vocational experts whose advice was obtained without regard to whether the advice was relied upon in making the benefit determination.

(3) Claimants and this Plan may have other voluntary alternative dispute resolution options, such as mediation. For available options, Claimants could contact their local U.S. Department of Labor Office and their State insurance regulatory agency.

(j) Exhaustion of Remedies.

(1) If a Claimant fails to file a request for review of a Denial, in whole or in part, of benefits in accordance with the procedures herein outlined, such Claimant will have no right to review and no right to bring action, at law or in equity, in any court and the Denial of the claim will become final and binding on all persons for all purposes.

(2) With respect to claims for Health Benefits, except as provided under paragraph (3) below, if the Claims Supervisor fails to strictly adhere to all the requirements with respect to a claim under this Section 13.02, the Claimant is deemed to have exhausted the internal claims procedure with respect to such claims. Accordingly, the Claimant may initiate an External Review as outlined in Section 13.03.

(3) Notwithstanding paragraph (2) above, the internal claims procedure with respect to Health Benefits claims will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant, so long as the Claims Supervisor demonstrates that the violation was for good cause or due to matters beyond the control of the Claims Supervisor and that the violation occurred in the context of an ongoing, good faith exchange of information between the Claims Supervisor and the Claimant. This exception is not available if the violation is part of a pattern of violations by the Claims Supervisor. The Claimant may request a written explanation of the violation from the Claims Supervisor, and the Claims Supervisor shall provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the process outlined in Section 13.02 to be deemed exhausted. If the IRO or a court rejects the Claimant's request for immediate review due to deemed exhaustion on the basis that the Claims Supervisor met the standards for the exception described in this paragraph, the Claimant shall have the right to resubmit and pursue the internal Appeal of the Health Benefits claim. In such case, within a reasonable time after the IRO or court rejects the claim for immediate review (not to exceed

10 days), the Claims Supervisor shall provide the Claimant with notice of the opportunity to resubmit and pursue the internal Appeal of the Health Benefits claim. Time periods for re-filing the Health Benefits claim shall begin to run upon the Claimant's receipt of such notice.

(k) Chart of Time Limits for Health Benefits and Dental Benefits Claims.

	TYPE OF CLAIM		
Maximum Time Limits	**Urgent Care Claims**	**Pre-Service Claims**	**Post-Service Claims**
Initial Claim Decision (*when no additional information is needed*)	**72 hours** after receipt of claim	**15 days** after receipt of claim	**30 days** after receipt of claim
Extensions for Initial Claim Decision	None	**15-day extension** for matters beyond Claims Supervisor's control The Claims Supervisor will notify claimant before end of initial claim review period of the circumstances requiring the extension and the expected date of decision. The Claims Supervisor may – but is not required to – grant an extension due to claimant's failure to submit information needed to decide initial claim. If granted, the notice will describe needed information.	
Notification to Claimant of Additional Information Needed to Decide Initial Claim	**24 hours** after receipt of incomplete claim	N/A	N/A
Notification to Claimant of Failure to Follow Proper Procedures	**24 hours** after receipt of improper claim	**5 days** after receipt of improper claim	N/A
Claimant to Provide Requested Information (*when applicable*)	**48 hours** after receipt of notice (may permit additional time)	**45 days** after receipt of notice (may permit additional time)	
Initial Claim Decision (*when additional information is needed*)	**48 hours** after earlier of: • receipt of additional information from claimant, or • end of time period given to claimant to provide additional information (48 hours)	**15 days** after earlier of: • receipt of additional information from claimant, or • end of time period given to claimant to provide additional information (45 days)	
Appeal Deadline	**180 days** after receipt of denial by claimant	**180 days** after receipt of denial by claimant	
Appeal Decision	**72 hours** after receipt of appeal (applies to both one level and two level appeals processes)	**30 days** after receipt of appeal	**60 days** after receipt of appeal

Section 13.03. External Review Process

(a) Application and Scope of Federal External Review Process for Health Benefits.

(1) Subject to paragraph (2) below, upon receipt of a Final Denial (including a deemed Final Denial) with respect to Health Benefits, the Claimant may apply for External Review as provided in this Section 13.03. Upon receipt of a Denial with respect to Health Benefits that is not a Final Denial, the Claimant may only apply for External Review if the claim is eligible for expedited External Review for Urgent Care Claims.

(2) The External Review process applies to:

(A) A Final Denial or eligible Denial with respect to Health Benefits that involve medical judgment, including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational; and

(B) A Rescission of coverage under the Health Benefits (whether or not the Rescission has any effect on any particular benefit at that time).

(b) Standard External Review Process for Claims for Health Benefits.

(1) Timing of Request for External Review. The Claimant must file a request for External Review of a Health Benefits claim with the Claims Supervisor no later than the date which is four months following the date of receipt of a notice of Final Denial. If there is no corresponding date four months after the date of receipt of such notice, then the request must be filed by the first day of the fifth month following receipt of the notice (*e.g.*, if a Final Denial is received on October 30, request must be made by the following March 1). If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(2) Preliminary Review. The Claims Supervisor shall complete a preliminary review of the request for External Review within five business days to determine whether (A) the Claimant is or was covered under the Plan at the time the covered service was requested or provided, as applicable; (B) the type of claim is eligible for External Review; (C) the Claimant has exhausted (or is deemed to have exhausted) the Plan's internal claims procedure under Section 13.02; and (D) the Claimant has provided all the information and forms required to process an External Review. The Claims Supervisor shall issue a notification to the Claimant within one business day of completing the preliminary review. If the request is complete, but ineligible for External Review, the notification shall include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification shall describe the information or materials needed to make the request complete, and the Claimant shall be allowed to perfect the request for External Review by the later of the four month filing period described in paragraph (1) above, or within the 48 hour period following the receipt of the notification.

(3) Referral to Independent Review Organization (IRO). The Claims Supervisor shall assign an IRO to the Claimant's request for External Review. Upon assignment, the IRO will undertake the following tasks with respect to the request for External Review:

(A) Timely notify the Claimant in writing of the request's eligibility and acceptance for External Review. This notice will include a statement that the Claimant may submit in writing to the IRO, within 10 business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

(B) Review all documents and any information considered in making a Final Denial received by the Claims Supervisor. The Claims Supervisor shall provide the IRO with such documents and information within five business days after the date of assignment of the IRO. Failure by the Claims Supervisor to timely provide the documents and information shall not delay the conduct of the External Review. If the Claims Supervisor fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Final Denial. In such case, the IRO shall notify the Claimant and the Claims Supervisor of its decision within one business day.

(C) Forward any information submitted by the Claimant to the Claims Supervisor within one business day of receipt. Upon receipt of any such information, the Claims Supervisor may reconsider its Final Denial that is the subject of the External Review. Reconsideration by the Claims Supervisor must not delay the External Review. The External Review may be terminated as a result of reconsideration only if the Claims Supervisor decides to reverse its Final Denial and provide coverage or payment. In such case, the Claims Supervisor must provide written notice of its decision to the Claimant and IRO within one business day, and the IRO shall then terminate the External Review.

(D) Review all information and documents timely received under a *de novo* standard. The IRO shall not be bound by any decisions or conclusions reached during the Claims Supervisor's internal claims and Appeals process. In addition to the information and documents provided, the IRO, to the extent the information and documents are available and the IRO considers them appropriate, shall further consider the following in reaching a decision: (i) the Claimant's medical records; (ii) the attending health care professional's recommendation; (iii) reports from appropriate health care professionals and other documents submitted by the Claims Supervisor, the Claimant, or the Claimant's physician; (iv) the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law; (v) appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations; (vi) any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the

terms of the Plan or with applicable law; and (vii) the opinion of the IRO's clinical reviewer(s) after considering the information described in this paragraph to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.

(4) Notice of Final External Review Decision. The IRO shall provide written notice of Final External Review Decision within 45 days after the IRO receives the request for External Review. Such notice shall be delivered to the Claimant and the Claims Supervisor and shall contain the following: (A) a general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous Denial); (B) the date the IRO received the assignment to conduct External Review and the date of the Final External Review Decision; (C) references to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching the decision; (D) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied upon in making its decision; (E) a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or the Claimant; (F) a statement that judicial review may be available to the Claimant; and (G) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

(5) Reversal of Plan's Decision. If the Final Denial of the Claims Supervisor is reversed by the Final External Review Decision, the Plan shall immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for a claim, upon receipt of notice of such reversal.

(6) Maintenance of Records. The IROs shall maintain records of all claims and notices associated with an External Review for six years. An IRO must make such records available for examination by the Claimant, the Claims Supervisor, or a State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

(c) Expedited External Review Process for Health Benefits.

(1) Application of Expedited External Review. The Plan shall allow the Claimant to make a request for expedited External Review at the time the Claimant receives either:

(A) A Denial with respect to Health Benefits, if the Denial involves a medical condition of the Claimant for which the timeframe for completion of an internal Appeal of an Urgent Care Claim would seriously jeopardize the Claimant's life or health or would jeopardize the Claimant's ability to regain maximum

function and the Claimant has filed a request for an Appeal of an Urgent Care Claim; or

(B) A Final Denial with respect to Health Benefits, if the Claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the Claimant's life or health or would jeopardize the Claimant's ability to regain maximum function, or if the Final Denial concerns admission, availability of care, continued stay, or a health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

(2) Preliminary Review. Immediately upon receipt of a request for expedited External Review, the Claims Supervisor must determine whether the request meets the reviewability requirements set forth in paragraph (1) above. The Claims Supervisor shall immediately send a notice that meets the requirements set forth in Section 13.03(b)(2) above for standard External Review of the Claimant for its eligibility determination.

(3) Referral to Independent Review Organization (IRO). Upon a determination that a request is eligible for expedited External Review following the preliminary review, the Claims Supervisor shall assign an IRO pursuant to the requirements set forth in Section 13.03(b)(3) above for standard External Review. The Claims Supervisor must provide or transmit all necessary documents and information considered in making the Denial or Final Denial determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the information or documents described under Section 13.03(b)(3)(D) above under the procedures for standard External Review. In reaching a decision, the assigned IRO shall review the claim *de novo* and is not bound by any decisions or conclusions reached during the Claims Supervisor's internal claims and Appeals process.

(4) Notice of Final External Review Decision. The IRO shall provide notice of Final External Review Decision, in accordance with the requirements set forth in Section 13.03(b)(4) above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to the Claimant and the Claims Supervisor.

(d) Form and Manner of Notices Pertaining to Claims under the Health Benefits. Notices provided under Section 13.02 and Section 13.03 with respect to Health Benefits shall be provided in a culturally and linguistically appropriate manner pursuant to Department of Labor regulations. Accordingly, with respect to an address in any United States county to which a notice is sent, if 10% or more of the population residing in the county is literate only in the same non-English language (the "applicable non-English language"), the Claims Supervisor will: (1) provide oral language services (such as a telephone customer assistance hotline) that include answering questions in the applicable non-English language; (2) provide notices sent with respect to Health Benefits claims in the applicable non-English language upon request; and (3) include a statement

in the English versions of all notices sent with respect to Health Benefits claims, prominently displayed in the applicable non-English language, clearly indicating how to access the language services provided by the Plan.

ARTICLE XIV.
SUBROGATION AND REIMBURSEMENT RIGHTS

Section 14.01. Right of Subrogation and Reimbursement.

The following provisions shall apply to the subrogation and reimbursement rights of this Plan, including the Health Benefits and Dental Benefits incorporated hereunder. The Plan has the right to full subrogation and reimbursement of any and all amounts paid by the Plan to, or on behalf of, a Covered Person, for which a third party is allegedly responsible. The Plan shall have a lien against such funds, and the right to impose a constructive trust upon such funds, and shall be reimbursed therefrom.

Section 14.02. Funds to Which Subrogation and Reimbursement Rights Apply.

The Plan's subrogation and reimbursement rights apply if the Covered Person receives, or has the right to receive, any sum of money, regardless of whether it is characterized as amounts paid for medical expenses or otherwise, paid or payable from any person, plan, or legal entity that is legally obligated to make payments as a result of a judgment, settlement, or otherwise, arising out of any act or omission of any third party, (whether a third party or another Covered Person under the Plan): (a) who is allegedly wholly or partially liable for costs or expenses incurred by the Covered Person, in connection for which the Plan provided benefits to, or on behalf of, such Covered Person; or (b) whose act or omission allegedly caused injury or sickness to the Covered Person, in connection for which the Plan provided benefits to, or on behalf of, such Covered Person.

Section 14.03. Agreement to Hold Recovery in Trust.

If a payment is made under this Plan, and the person to or for whom it is made recovers monies from a third party described in Section 14.03 as a result of settlement, judgment, or otherwise, that person shall hold in trust for the Plan the proceeds of such recovery and reimburse the Plan to the extent of its payments.

Section 14.04. Disclaimer of Make Whole Doctrine.

The Plan has the right to be paid first and in full from any settlement or judgment, regardless of whether the Covered Person has been "made whole." The Plan's right is a first priority lien. The Plan's rights shall continue until the Covered Person's obligations hereunder to the Plan are fully discharged, even though the Covered Person does not receive full compensation or recovery for his or her injuries, damages, loss or debt. This right to subrogation pro tanto shall exist in all cases.

Section 14.05. Disclaimer of Common Fund Doctrine.

The Covered Person shall be responsible for all expenses of recovery from such third parties or other persons, including but not limited to, all attorneys' fees incurred in collection of such third-party payments, or payments by other persons. Any attorneys' fees and/or expenses owed by the Covered Person shall not reduce the amount of reimbursement due to the Plan.

Section 14.06. Obligations of the Covered Person.

The Covered Person shall furnish any and all information and assistance requested by the Administrator. If requested, the Covered Person shall execute and deliver to the Administrator a subrogation and reimbursement agreement before or after any payment of benefits by the Plan. The Covered Person shall not discharge or release any party from any alleged obligation to the Covered Person or take any other action that could impair the Plan's rights to subrogation and reimbursement without the written authorization of the Administrator.

Section 14.07. Plan's Right to Subrogation.

If the Covered Person or anyone acting on his or her behalf has not taken action to pursue his or her rights against a third party described in Section 14.01 above or any other persons to obtain a judgment, settlement or other recovery, the Administrator or its designee, upon giving 30 days' written notice to the Covered Person, shall have the right to take such action in the name of the Covered Person to recover that amount of benefits paid under the Plan; provided, however, that any such action taken without the consent of the Covered Person shall be without prejudice to such Covered Person.

Section 14.08. Enforcement of Plan's Right to Reimbursement.

If a Covered Person fails or refuses to comply with these provisions by reimbursing the Plan as required herein, the Plan has the right to impose a constructive trust over any and all funds received by the Covered Person, or as to which the Covered Person has the right to receive. The Plan, through the Administrator, has the authority to pursue any and all legal and equitable relief available to enforce the rights contained in this Article, against any and all appropriate parties who may be in possession of the funds described herein.

Section 14.09. Withholding of Payments for Benefits.

The Plan may withhold payment of benefits for an injury when a party other than the Covered Person or the Plan may be liable for expenses for that injury until liability is legally determined. In the event that any payment is made under the Plan for which any party other than the Covered Person or the Plan may be liable, the Plan shall be subrogated to all rights of recovery of the Covered Person to the extent of payments by the Plan and shall have the right to be reimbursed as set forth in this Article.

Section 14.10. Failure to Comply.

If a Covered Person fails to comply with the requirements under this Article, the Covered Person shall not be eligible to receive any benefits, services or payments under the Plan for any

sickness or injury until there is compliance, regardless of whether such benefits are related to the act or omission of such third party or other persons.

Section 14.11. Future Claims Excluded.

If the Covered Person receives any sum of money described in Section 14.02, the Plan shall have no further obligation to pay benefits relating in any way to future claims for the same or related injuries, including but not limited to any complications thereof, for which the Covered Person received such sum of money, and benefits for such future claims shall be excluded.

Section 14.12. Discretionary Authority of Administrator.

The Plan, through the Administrator, shall have full discretionary authority to interpret the provisions of this Article, and to administer and pursue the Plan's subrogation and reimbursement rights. It shall be within the discretionary authority of the Administrator to resolve, settle, or otherwise compromise its subrogation and reimbursement rights when appropriate. The Administrator is under no legal obligation to reduce its lien or reimbursement rights unless, in its sole discretion, it determines that doing so is appropriate.

ARTICLE XV.
AMENDMENT OR TERMINATION PROCEDURE

Section 15.01. Amendment of Plan.

The College, through action of the State Board of Trustees and the President of the College or his or her designee, will have the right, in their sole and absolute discretion, to amend or modify the Health Benefits and Dental Benefits provided under the Plan at any time and from time to time and to any extent they may deem advisable. Such modification or amendment will be duly incorporated in writing, which will be signed by the President of the College or his or her designee. Any amendment or modification of the Plan will be effective as determined by the College. Any such amendment may be effective retroactively.

Section 15.02. Termination of Plan.

The College, through action of the State Board of Trustees and the President of the College or his or her designee, will have the right, in their sole and absolute discretion, to terminate the Health Benefits and Dental Benefits provided under the Plan at any time. Termination will be effective as determined by the College.

ARTICLE XVI.
MISCELLANEOUS

Section 16.01. Nonalienation.

(a) Except as otherwise required pursuant to a qualified medical child support order, no benefit under the Plan prior to actual receipt thereof by an Eligible Employee, Eligible Retiree, Surviving Spouse, Dependent, or his or her beneficiary shall be subject to any debt, liability, contract, engagement, or tort of such individual, nor subject to anticipation, sale, assignment,

transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation, or any other voluntary or involuntary alienation or other legal or equitable process, nor transferable by operation of law except as may be provided in the Plan.

(b) Any purported assignment to a medical provider shall be considered by the Plan to be merely a direction from a Covered Person to provide direct payment to the medical provider as a facilitation of payment and shall not be construed as an assignment to the medical provider regardless of its content. The Plan's direct payment to a medical provider pursuant to such a direction shall not constitute a recognition of a legal assignment.

Section 16.02. Additional Taxes or Penalties.

If there are any taxes or penalties payable by the College on behalf of a Covered Person, such taxes or penalties shall be payable by the Covered Person to the College to the extent such taxes would have been originally payable by the Covered Person had this Plan not been in existence.

Section 16.03. No Guarantee of Tax Consequences.

Neither the Administrator nor the College makes any commitment or guarantee that any amounts paid to or for the benefit of a Covered Person under the Plan shall be excludable from the Covered Person's gross income for federal, state, or local income tax purposes or for Social Security tax purposes, or that any other federal or state tax treatment shall apply to or be available to any Covered Person. It shall be the obligation of each Covered Person to determine whether payment under the Plan is excludable from the Covered Person's gross income for federal, state, and local income tax purposes, and Social Security tax purposes, and to notify the College if the Covered Person has reason to believe that any such payment is not excludable.

Section 16.04. Employment of Consultants.

The Administrator, or a fiduciary named by the Administrator pursuant to the Plan, may employ one or more persons to render advice with regard to their respective responsibilities under the Plan.

Section 16.05. Designation of Fiduciaries.

The Administrator may designate another person or persons to carry out any fiduciary responsibility of the Administrator under the Plan. The Administrator shall not be liable for any act or omission of such person in carrying out such responsibility, except as may be otherwise provided under state law.

Section 16.06. Fiduciary Responsibilities.

To the extent permitted under state law, no fiduciary of the Plan shall be liable for any act or omission in carrying out the fiduciary's responsibilities under the Plan.

Section 16.07. Allocation of Fiduciary Responsibilities.

To the extent permitted under state law, each fiduciary under the Plan shall be responsible only for the specific duties assigned under the Plan and shall not be directly or indirectly responsible for the duties assigned to another fiduciary.

Section 16.08. Limitation of Rights and Obligations.

Neither the establishment nor maintenance of the Plan nor any amendment thereof, nor the purchase of any benefit contract or insurance policy, nor any act or omission under the Plan or resulting from the operation of the Plan shall be construed:

(a) as conferring upon any Covered Person, beneficiary, or any other person any right or claim against the College, Claims Supervisor, or the Administrator, except to the extent that such right or claim shall be specifically expressed and provided in the Plan or provided under state law;

(b) as creating any responsibility or liability of the College, Administrator, or the Claims Supervisor for the validity or effect of the Plan;

(c) as a contract or agreement between the College and any Eligible Employee, Eligible Retiree, or other person;

(d) as being consideration for, or an inducement or condition of, employment of any Eligible Employee or other person, or as affecting or restricting in any manner or to any extent whatsoever the rights or obligations of the College or any Eligible Employee or other person to continue or terminate the employment relationship at any time; or

(e) as giving any Eligible Employee or any other person the right to be retained in the service of the College or to interfere with the right of the College to discharge any Eligible Employee at any time.

Section 16.09. Notice.

Any notice given under the Plan shall be sufficient if given to the Administrator, when addressed to its office; if given to the Claims Supervisor, when addressed to its office; or if given to a Covered Person when addressed to the Covered Person at his or her address as it appears in the records of the Administrator or the Claims Supervisor.

Section 16.10. Disclaimer of Liability.

Nothing contained herein shall confer upon a Covered Person any claim, right, or cause of action, either at law or at equity, against the Plan, the Administrator, the College, or the Claims Supervisor for the acts or omissions or any provider of services or supplies for any benefits provided under the Plan.

Section 16.11. Right of Recovery.

If the College, the Administrator, or the Claims Supervisor makes any payment that according to the terms of the Plan and the benefits provided hereunder as defined in the Schedules of Benefits should not have been made, the College, the Administrator, or the Claims Supervisor may recover that incorrect payment, whether or not it was made due to the College's, the Administrator's, or the Claims Supervisor's own error, from the person to whom it was made, or from any other appropriate party. If any such incorrect payment is made directly to a Covered Person, then the College, the Administrator, or the Claims Supervisor may deduct it when making future payments directly to that Covered Person.

Section 16.12. Legal Counsel.

The Administrator and/or its designee, may from time to time consult with counsel, who may be counsel for the College, and shall be fully protected in acting upon the advice of such counsel.

Section 16.13. Evidence of Action.

All orders, requests, and instructions to the Administrator or the Claims Supervisor by the College or by any duly authorized representative, shall be in writing and the Administrator and the Claims Supervisor shall act and shall be fully protected in acting in accordance with such orders, requests, and instructions.

Section 16.14. Audit.

If an audit of the Plan is required for any Plan Year, the Administrator shall engage an independent qualified public accountant.

Section 16.15. Protective Clause.

Neither the College nor the Administrator shall be responsible for the validity of any contract of insurance or other benefit contract or policy by any benefit provider issued to the College or for the failure on the part of any insurance company or other benefit provider to make payments thereunder.

Section 16.16. Receipt and Release.

Any payments to a Covered Person shall, to the extent thereof, be in full satisfaction of the claim of such Covered Person being paid thereby, and the Administrator may condition payment thereof on the delivery by the Covered Person of the duly executed receipt and release in such form as may be determined by the Administrator.

Section 16.17. Legal Actions.

If the Administrator is made a party to any legal action regarding the Plan, except for a breach of fiduciary responsibility of such person or persons, any and all costs and expenses,

including reasonable attorneys' fees, incurred by the Administrator in connection with such proceeding shall be paid from the assets of the Plan unless paid by the College.

Section 16.18. Reliance.

The Administrator shall not incur any liability in acting upon any notice, request, signed letter, telegram, or other paper or document believed by the Administrator to be genuine or to be executed or sent by an authorized person.

Section 16.19. Misrepresentation.

(a) Health Benefits coverage. Any act, practice, or omission that constitutes fraud, or any intentional misrepresentation of material fact on the part of the Covered Person in making application for coverage or reclassification of coverage, in applying for and/or for obtaining Health Benefits coverage under the Plan, or in any other course of dealing with the Plan, may result in a retroactive cancellation or discontinuance of coverage.

(b) Dental Benefits coverage. Any misrepresentation on the part of the Covered Person when applying for coverage or reclassification of coverage or when applying for and/or obtaining benefits, will cause Plan coverage to be null and void from the date coverage began.

Section 16.20. Qualified Medical Child Support Orders.

The Plan shall provide Health Benefits and Dental Benefits in accordance with the applicable requirements of a qualified medical child support order received by the Plan. If the Plan receives a medical child support order, the Administrator shall promptly notify the Eligible Employee or Eligible Retiree, and each Child identified in the order, of the receipt of such order and the Plan's procedures for determining whether the order is a qualified medical child support order. Within a reasonable time after receipt of such order, the Administrator shall determine whether the order is a qualified medical child support order and notify each individual involved of the determination.

Section 16.21. Counterparts.

The Plan may be executed in any number of counterparts, each of which shall be deemed to be an original. All counterparts shall constitute but one and the same instrument and shall be evidenced by any one counterpart.

Section 16.22. Entire Plan.

The Plan document and the documents incorporated by reference herein shall constitute the only legally governing documents for the Plan. No oral statement or other communication shall amend or modify any provision of the Plan as set forth herein.

IN WITNESS WHEREOF, the College has caused the Plan to be executed as of the date set forth below, to be effective as of the date identified above.

"COLLEGE"

Ivy Tech Community College of Indiana

By:_____

Title: _____

Printed Name: _____

Date: _____

SCHEDULE A

SCHEDULE OF BENEFITS

PLAN BENEFIT	CLAIMS SUPERVISOR	FUNDING	POLICY OR CONTRACT NUMBER
Health Benefits	Anthem Insurance Companies (medical benefits) CVS Caremark (prescription drug benefits)	Self-insured	IN2000
Dental Benefits	Delta Dental	Self-insured	IN070549000

The foregoing Schedule A was adopted in whole or in part by the College and may be revised, modified, changed, or added to pursuant to Article III of the Plan.

"COLLEGE"

Ivy Tech Community College of Indiana

By: _____

Title: _____

Printed Name: _____

Date: _____

SCHEDULE B

BENEFIT PLANS AND CONTRACTS

Documents incorporated by reference into the Plan, and made a part hereof, include the following:

1. The Anthem Health Benefits Booklet for Ivy Tech Community College of Indiana.

2. The Delta Dental Benefits Booklet for Ivy Tech Community College of Indiana.

The foregoing Schedule B was adopted in whole or in part by the College and may be revised, modified, changed, or added to pursuant to Article III of the Plan.

"COLLEGE"

Ivy Tech Community College of Indiana

By:_____

Title: _____

Printed Name: _____

Date: _____

APPENDIX A

IVY TECH COMMUNITY COLLEGE OF INDIANA
POLICY FOR DETERMINING FULL-TIME EMPLOYMENT STATUS UNDER INTERNAL REVENUE CODE SECTION 4980H

I. PURPOSE

This Appendix A sets forth the Ivy Tech Community College of Indiana Policy for Determining Full-Time Employment Status Under Internal Revenue Code Section 4980H ("Policy"). This Policy is intended to set forth the methods by which Ivy Tech Community College of Indiana (the "College") will determine whether an Employee is a Full-Time Employee under Section 4980H of the Internal Revenue Code ("Code") for purposes of:

(i) meeting the College's reporting obligations under Code Section 6056; and

(ii) determining a category of eligibility for Health Benefits under the Ivy Tech Community College Health and Dental Care Plan ("Plan").

The determination that an Employee is a Full-Time Employee under this Policy is for these two purposes only and does not affect the College's determination of full-time employee status for any other purpose.

This Policy is part of and incorporated by reference into the Plan. This Policy controls to the extent that there are conflicts with the Plan. The Plan may provide additional categories of eligibility that are not based on the determination of whether an Employee is a Full-Time Employee under this Policy. The determination of whether an Employee is eligible for Health Benefits under the Plan under any such separate category is beyond the scope of this Policy and is governed by the terms of the Plan.

II. POLICY

An Employee who is determined by the College to be a Full-Time Employee during a Measurement Period shall be reported as a Full-Time Employee during the corresponding Stability Period for the applicable periods under Code Section 6056. Such Full-Time Employee will also have an opportunity to elect, change, or decline Health Benefits coverage for himself or herself and his or her Dependents during the related Administrative Period.

This Policy is intended to satisfy the rules under Treasury Regulation Section 54.4980H-3, will be interpreted consistently therewith, and will be revised to conform to changes that may be made by any subsequent guidance.

III. EFFECTIVE DATE

This Policy was originally effective July 1, 2015, and is now being revised effective January 1, 2021.

IV. DEFINITIONS

Capitalized terms in this Policy have the meaning ascribed to them in the Plan. Capitalized terms that are not defined in the Plan have the following meanings:

- **Administrative Period –** The period immediately following a Measurement Period during which the College identifies which Employees are Eligible Employees and conducts enrollment under the Plan.

  - For a new Variable Hour Employee, Seasonal Employee, or Part-Time Employee, the initial Administrative Period is the one month period immediately following the Employee's initial Measurement Period. Thereafter, such Employee will have the same Administrative Period as an Ongoing Employee.

  - For Ongoing Employees, the Administrative Period is the two and one-half month period immediately following the standard Measurement Period.

- **Eligible Employee –** An Eligible Employee as defined under the Plan, and includes an Employee who is determined to be a Full-Time Employee pursuant to this Policy.

- **Employment Break Period –** A period of at least four consecutive weeks (disregarding Special Unpaid Leave) during which an Employee of the College is not credited with Hours of Service (*e.g.*, summer break). For purposes of measuring an Employment Break Period, a week means the seven day period from Sunday to Saturday.

- **Full-Time Employee –** An Employee who is employed an average of at least 30 Hours of Service per week with the College.

- **Hour of Service –**

  - each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the College; and

  - each hour for which an Employee is paid, or entitled to payment by the College for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence (as defined in 29 CFR 2530.200b-2(a)).

  Notwithstanding the preceding, an Hour of Service shall not include any hour for services:

  - performed as a bona fide volunteer;

  - performed as part of a Federal Work-Study Program or substantially similar program of a State or political subdivision thereof; or

  - to the extent the compensation for such services constitutes income from sources outside the United States.

- **Measurement Period –** The period used by the College to determine whether an Employee is a Full-Time Employee.

  - For a new Variable Hour Employee, Seasonal Employee, or Part-Time Employee, the initial Measurement Period is the Employee's initial 12 months of employment with the College beginning with the first day of the month following date of hire. At such time that a new Variable Hour Employee, Seasonal Employee, or Part-Time Employee has been employed for an entire standard Measurement Period, he or she will be tested under that standard Measurement Period at the same time and under the same conditions as apply to other Ongoing Employees.

  - For Ongoing Employees, the standard Measurement Period is the 12-month period that begins October 15 and ends the following October 14.

- **Ongoing Employee** – An Employee who has been employed by the College for at least one complete standard Measurement Period.

- **Part-Time Employee –** A new Employee who the College reasonably expects to be employed on average less than 30 Hours of Service per week during the initial Measurement Period, based on the facts and circumstances at the Employee's start date.

- **Seasonal Employee –** A new Employee who is hired into a position for which the customary annual employment is six months or less. Customary annual employment means that by the nature of the position, an Employee in this position typically works for a period of six months or less, and that period begins each calendar year in approximately the same part of the year, such as summer or winter.

- **Special Unpaid Leave –** Unpaid leave under the Family and Medical Leave Act, unpaid leave subject to the Uniformed Services Employment and Reemployment Rights Act, and unpaid leave on account of jury duty.

- **Stability Period –** The period that follows, and is associated with, a Measurement Period (and related Administrative Period) during which an Employee's status as a Full-Time Employee (or not a Full-Time Employee, as the case may be) will be generally locked in place.

  - For a new Variable Hour Employee, Seasonal Employee, or Part-Time Employee, the initial Stability Period is the 12-month period following the Employee's initial Measurement Period and related Administrative Period. Thereafter, such Employee will have the same Stability Period as an Ongoing Employee.

  - For Ongoing Employees, the Stability Period is the 12-month period that begins January 1 and ends December 31.

- **Variable Hour Employees –** A new Employee for whom, based on the facts and circumstances at the Employee's hire date, the College cannot determine whether the Employee is reasonably expected to be employed on average at least 30 Hours of Service per week during the initial Measurement Period because the Employee's hours are variable or otherwise uncertain.

V. PROCEDURES FOR COUNTING AND CREDITING HOURS OF SERVICE

A. Hourly Employees – The College will calculate actual Hours of Service from records of hours worked and hours for which payment is made or due for all Employees who are paid by the College on an hourly basis.

B. Salaried Employees – Except as noted below, the College will credit Employees who are paid by the College on a salaried basis with 8 Hours of Service for each day in which the Employee would be required to be credited with at least one Hour of Service if the Employee were paid on an hourly basis.

C. Faculty Members/Adjuncts – The College will credit Hours of Service for Employees who are faculty members or adjuncts in accordance with the following formula:

- 2.25 Hours of Service per week for each contact hour assigned to the faculty member or adjunct. This crediting method takes into account time for preparation, teaching, grading and similar activities needed to teach a course.

- Hours of Service for other work assigned to a faculty member or adjunct, such as for committee meetings, student advising, department duties, administrative duties, research, professional development, and/or any other additional non-teaching work assignment, shall be counted the same as for hourly employees.

D. Corporate College Instructors – The College will credit one Hour of Service for each contact hour completed by Employees who are Corporate College instructors.

VI. APPLICATION OF LOOK-BACK MEASUREMENT METHOD

A. Ongoing Employees

- An Ongoing Employee is a Full-Time Employee for a Stability Period if, during the preceding standard Measurement Period, the Ongoing Employee worked an average of at least 30 Hours of Service per week. Such Full-Time Employee will have an opportunity to elect, change, or decline Health Benefits coverage for himself or herself and his or her dependents during the related Administrative Period.

- Notwithstanding the previous paragraph, the rule in this paragraph applies to an Ongoing Employee who has been continuously offered Health Benefits coverage under the Plan since no later than the first day of the calendar month following the Employee's initial three full calendar months of employment and who experiences a change in employment status during a Stability Period, such that, if the Employee had begun employment in the new position, the Employee would have reasonably been expected not to be employed on average at least 30 Hours of Service per week. Such Employee will not be treated as a Full-Time Employee beginning on the

first day of the fourth full calendar month following the change in employment status, provided that the Employee actually averages less than 30 Hours of Service per week for each of the three full calendar months following the change in employment status. The determination of Full-Time Employee status for such Employee shall be made on a monthly basis until the end of the first full Measurement Period (and related Administrative Period) that is completed after the change in employment status occurs.

- An Ongoing Employee who does not work an average of at least 30 Hours of Service per week over a standard Measurement Period is not a Full-Time Employee for the subsequent Stability Period (although such Employee may nonetheless fall within a separate eligibility category for Health Benefits coverage not addressed by this Policy). Notwithstanding the preceding, if an Employee described in this paragraph experiences a change in employment status during the subsequent Stability Period such that, if the Employee had begun employment in the new position, the Employee would have reasonably been expected to be a Full-Time Employee, then, such Employee will be treated as a Full-Time Employee as of the first day of the next calendar month following the change in employment status and shall have an opportunity to elect Health Benefits coverage for himself or herself and his or her dependents (to the extent not already covered under the Plan under a separate eligibility category).

- If an Ongoing Employee goes on a paid or unpaid leave of absence from the College, the Employee will continue to be a Full-Time Employee or not a Full-Time Employee, as applicable, for the remainder of the Stability Period in which the leave begins. Thereafter, the Employee's status as a Full-Time Employee or not a Full-Time Employee for the subsequent Stability Period will be determined based on Hours of Service during the preceding Measurement Period, taking into account any Special Unpaid Leave and Employment Break Periods. The treatment of such Ongoing Employee as a new Employee or a continuing Employee upon resumption of services shall be determined under the rehire rules defined later in this Policy.

B. New Full-Time Employees

- For purposes of reporting under Code Section 6056, a new Employee is a Full-Time Employee for each calendar month only if he or she is actually employed an average of at least 30 Hours of Service per week with the College.

- For purposes of the Plan, a new Employee is subject to the following rules:

  - A new Employee who is reasonably expected at the Employee's start date to be a Full-Time Employee (and who is not a Seasonal Employee) will be a Full-Time Employee for each calendar month until such time that the new Employee has been employed for an entire standard Measurement Period, at which time he or she will be tested under that

standard Measurement Period at the same time and under the same conditions as apply to other Ongoing Employees. Such Full-Time Employee will have an opportunity to elect, change, or decline Health Benefits coverage for himself or herself and his or her dependents during an election period related to the Employee's start date.

- If a new Employee described in this section experiences a change in employment status before the Employee has been employed for an entire standard Measurement Period, such that, if the Employee had begun employment in the new position, the Employee would have reasonably been expected not to be employed on average at least 30 Hours of Service per week, then, beginning on the first day of the next calendar month following the change in employment status, the determination of Full-Time Employee status for such Employee shall be made on a monthly basis until such time that the new Employee has been employed for an entire standard Measurement Period, at which time he or she will be tested under that standard Measurement Period at the same time and under the same conditions as apply to other Ongoing Employees.

- If a new Employee described in this section goes on a paid or unpaid leave of absence from the College before the Employee has been employed for an entire standard Measurement Period, then beginning on the first day of the next calendar month following the date the leave of absence begins, the determination of Full-Time Employee status for such Employee shall be made on a monthly basis until such time that the new Employee has been employed for an entire standard Measurement Period, at which time he or she will be tested under that standard Measurement Period at the same time and under the same conditions as apply to other Ongoing Employees. Notwithstanding a determination that an Employee is not a Full-Time Employee with respect to a calendar month in which he or she is on a leave of absence, coverage under the Plan shall continue to the extent required under the FMLA, USERRA, or COBRA.

C. New Variable Hour Employees, Seasonal Employees, and Part-Time Employees

➢ New Variable Hour Employees, Seasonal Employees, and Part-Time Employees will be tested under an initial Measurement Period to determine whether they are Full-Time Employees.

- A new Variable Hour Employee, Seasonal Employee, or Part-Time Employee who works an average of at least 30 Hours of Service per week over his or her initial Measurement Period will be a Full-Time Employee for his or her initial Stability Period. Such Employee will have an opportunity to elect Health Benefits coverage for himself or

herself and his or her dependents during the related initial Administrative Period.

- A new Variable Hour Employee, Seasonal Employee, or Part-Time Employee who does not work an average of at least 30 Hours of Service per week over his or her initial Measurement Period will not be a Full-Time Employee for his or her initial Stability Period (although such Employee may nonetheless fall within a separate eligibility category for Health Benefits coverage not addressed by this Policy). Notwithstanding the preceding, if a new Variable Hour Employee, Seasonal Employee, or Part-Time Employee experiences a change in employment status during the subsequent Stability Period such that, if the Employee had begun employment in the new position, the Employee would have reasonably been expected to be a Full-Time Employee, then the College will treat the Employee as a Full-Time Employee on the first day of the next calendar month following the change in employment status. Such Employee shall have an opportunity to elect Health Benefits coverage for himself or herself and his or her dependents (to the extent not already covered under the Plan under a separate eligibility category).

- At such time that a new Variable Hour Employee, Seasonal Employee, or Part-Time Employee has been employed for an entire standard Measurement Period, he or she will be tested under that standard Measurement Period at the same time and under the same conditions as apply to other Ongoing Employees; provided, however, that a new Variable Hour Employee, Seasonal Employee, or Part-Time Employee who is determined to be a Full-Time Employee for his or her initial Stability Period will continue to be a Full-Time Employee through the end of that initial Stability Period, even if he or she is not determined to be a Full-Time Employee during the standard Measurement Period.

➢ If a new Variable Hour Employee, Seasonal Employee, or Part-Time Employee experiences a change in employment status before the end of the initial Measurement Period such that, if the Employee had begun employment in the new position, the Employee would have reasonably been expected to be a Full-Time Employee, the College will treat the Employee as a Full-Time Employee as of the first day of the next month following the date of the change in employment status, and such Employee shall have an opportunity to elect Health Benefits coverage for himself or herself and his or her dependents (to the extent not already covered under the Plan under a separate eligibility category).

VII. SPECIAL RULES

A. Factors for Determining Employee Status – For purposes of determining whether an Employee is reasonably expected at his or her start date to be a Full-Time Employee (who is not a Seasonal Employee), a Part-Time Employee, or a Variable

Hour Employee, the College will consider all of the facts and circumstances, including but not limited to the following factors:

- whether the Employee is replacing an Employee who was (or was not) a Full-Time Employee, Part-Time Employee, or a Variable Hour Employee;

- the extent to which Hours of Service of Ongoing Employees in the same or comparable positions have varied above and below an average of 30 Hours of Service per week during recent Measurement Periods; and

- whether the position was advertised, or otherwise communicated to the new Employee or otherwise documented (for example, through a contract or job description), as requiring Hours of Service that would average 30 (or more) Hours of Service per week, less than 30 Hours of Service per week, or may vary above and below an average of 30 Hours of Service per week.

No single factor is determinative. In determining an Employee's status, the College will not take into account the likelihood that the Employee may terminate employment with the College before the end of an initial Measurement Period, or the potential for, or likelihood of, an Employment Break Period in determining the College's expectation of future Hours of Service.

B. **Use of Payroll Periods –** For purposes of measuring the beginning and end of a Measurement Period with respect to Employees who are paid on a bi-weekly basis, the College will, in its discretion, treat as a Measurement Period a period that:

- begins on the first day of the bi-weekly payroll period, as applicable, that follows the payroll period that includes the date that would otherwise be the first day of the Measurement Period, and

- ends on the last day of the bi-weekly payroll period, as applicable, that includes the date that would otherwise be the last day of the Measurement Period.

C. **Exclusion of Special Unpaid Leave and Employment Break Periods –** The College will determine an Employee's average Hours of Service for a Measurement Period by (i) computing the average after excluding any Special Unpaid Leave and any Employment Break Period during that Measurement Period and (ii) by using that average as the average for the entire Measurement Period; provided, however, that no more than 501 Hours of Service related to Employment Break Periods (but not related to Special Unpaid Leaves) that occur during the Measurement Period will be excluded.

D. **Determination of Employee Status Upon Resumption of Services –** An Employee who either (i) terminates employment with the College and is subsequently rehired or (ii) resumes providing services to the College following a leave of absence in which he or she was not credited with any Hours of Service, will maintain his or her status as a Full-Time Employee or not a Full-Time Employee, as applicable, for the remainder of the Stability Period in which the

termination or leave occurred, unless the Employee can be treated as a new Employee. An Employee will be treated as a new Employee upon resumption of his or her services for the College only if he or she is not credited with an Hour of Service:

- for a period of at least 26 consecutive weeks; or
- for a period that is longer than the period of employment preceding the break and that is at least four weeks.

This rule applies only for purposes of this Policy.

VIII. ADMINISTRATION, REVIEW AND AMENDMENT OF POLICY

The College will administer Measurement Periods for new and Ongoing Employees, determine an Employee's status as a Full-Time Employee (or not a Full-Time Employee, as the case may be) during Administrative Periods, and provide Health Benefits coverage under the Plan during Stability Periods to Eligible Employees determined to be Full-Time Employees, all in accordance with this Policy and the terms of the Plan. The College has full and absolute discretionary authority to interpret the terms of this Policy to determine whether its Eligible Employees are Full-Time Employees under the Plan. Employees who have questions regarding this Policy may contact the Plan Administrator for more information.

The College will periodically review this Policy for compliance under applicable regulations and other guidance. The College has the right, in its sole and absolute discretion, to revise this Policy at any time to ensure legal compliance and to further the goals of the College.