

**WILLIAM MARSH RICE UNIVERSITY  
MEDICAL PLAN**

**EFFECTIVE: JULY 1, 2003**

**WILLIAM MARSH RICE UNIVERSITY  
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ARTICLE I  
INTRODUCTION

1.1 Establishment of Plan. The William Marsh Rice University (the “University”) hereby establishes the William Marsh Rice University Medical Plan (the “Plan”) effective July 1, 2003.

1.2 Plan Purpose. The purpose of the Plan is to provide health benefits to Participants and their Covered Dependents subject to the terms, conditions, and limitations set forth herein. It is intended that the Plan qualify as an accident and health plan within the meaning of Code Section 105(e) and that the benefits payable under the Plan be eligible for exclusion from gross income under Code Section 105(b).

1.3 Plan Funding. The Plan is unfunded and all contributions shall be considered a part of the general assets of the University and shall not be placed in trust. Nothing herein shall be construed to require the University to establish a trust or maintain any fund or segregate any amount for the benefit of Participants and their Covered Dependents unless otherwise required by law.

1.4 Plan Document. This document, made and entered into by University, and the attached Summaries of Coverage, are effective July 1, 2003 and evidences the terms of Plan, including but not limited to the requirements for enrollment, the types and amounts of benefits, and any other conditions or limitations regarding enrollment, coverage and benefits, pursuant to which health benefits shall be provided to Participants and their Covered Dependents.

ARTICLE II  
DEFINITIONS

2.1. Claims Administrator. “Claims Administrator” means such firm(s) as may be appointed from time to time by the University or the Plan Administrator to process benefit payments or to administer all or portion of the Plan’s claims and appeals procedures.

2.2. Code. “Code” means the Internal Revenue Code of 1986 and the regulations thereunder. Reference to a specific Code Section shall be deemed also to refer to any applicable regulations under that Section, and shall also include any comparable provisions of future legislation that amend, supplement, or supersede that specific Section.

2.3. Continuation Coverage. “Continuation Coverage” means that coverage which is required by the provisions of Part 6 of Subtitle B of ERISA (Sections 601 through 608) and Code Section 4980B(f) and (g), as each may be amended from time to time, and described in Article V.

2.4. Coverage Elections. “Coverage Elections” means the Coverage Option and Coverage Level elected (or deemed elected) by a Participant for a Coverage Period.

2.5. Coverage Level. “Coverage Level” means the coverage level that a Participant may elect under a Coverage Option. The Coverage Levels offered under a Coverage Option shall be determined by the University for each Plan Year or at such other times as it determines. The Coverage Levels offered under each Coverage Option as of July 1, 2003 are set forth in Section 6.2.

2.6. Coverage Option. “Coverage Option” means the coverage options offered under the Plan as determined by the University for each Plan Year or at such other times as it determines. The Coverage Options offered under the Plan as of July 1, 2003 are set forth in Section 6.1.

2.7. Coverage Period. “Coverage Period” means a 12-consecutive month period commencing each July 1; provided, however, if an Employee becomes an Eligible Employee after the start of a Coverage Period and elects to enroll in the Plan pursuant to Section 3.1, the initial Coverage Period is the period commencing on the date such Eligible Employee’s enrollment in the Plan is first effective and extending through the remainder of the Coverage Period.

2.8. Covered Dependent. “Covered Dependent” means a Dependent of a Participant who is enrolled in the Plan in accordance with the provisions of Section 3.2.

2.9. Dependent. “Dependent” means (i) the spouse or Domestic Partner of a Participant and (ii) an unmarried child of a Participant, including a natural child, legally adopted child, stepchild, child under legal guardianship or licensed foster care, child placed for adoption, or a grandchild under court-ordered custody, so long as the child is primarily dependent upon Participant for support and maintenance. The following are not Dependents:

- (a) A spouse following entry of divorce or legal separation.
- (b) A common-law spouse unless satisfactory proof, as determined by the University, of a common-law marriage is submitted to the University prior to enrollment in the Plan.
- (c) A child age 18 or older unless such child (i) lives in the Participant's home in which case the child shall continue to be a Dependent until he or she reaches age 25, (ii) is enrolled in an educational institution on a full-time basis in which case the child shall continue to be a Dependent until he or she reaches age 25 so long as over half of his or her support (within the meaning of Code Section 152) is provided by the Participant, or (iii) is unable to earn his or her own living because of a mental or physical disability which started prior to the earlier of the date the child ceased to live in the Participant's home or reached age 25 in which case the child shall continue to be a Dependent so long as over half of his or her support (within the meaning of Code Section 152) is provided by the Participant. Satisfactory proof (including where applicable, an objective medical examination, to determine mental or physical disability) must be submitted to the University at least 31 days before coverage would otherwise terminate and at such later times as may be requested by the University to ensure that a Participant's child continues to meet the eligibility criteria described in this subsection.
- (d) A child of a Domestic Partner unless (i) the Participant provides over half of his or her support (within the meaning of Code Section 152), (ii) the child lives in the Participant's home in a regular parent/child relationship and (iii) the child is otherwise not treated as a Dependent of the Participant under subsection (c).
- (e) A person who is a Covered Dependent of another Participant.

2.10. Domestic Partner. "Domestic Partner" means a person for whom a Participant has submitted a completed Affidavit of Domestic Partnership to the University and for whom the Participant has received a Domestic Partner Registration Certification from the University prior to Domestic Partner's enrollment in the Plan. For purposes of the Plan, the following shall apply:

(a) "Domestic Partner Registration Certification" means a certification issued by the University recognizing the domestic partner relationship.

(b) "Affidavit of Domestic Partnership" means an affidavit in which a Participant attests that the Participant and his or her partner: (i) are not related by blood closer than permissible by state law for marriage in their state of residence; (ii) are not married to or legally separated from another person; (iii) share the same regular and permanent residence; (iv) has made an exclusive mutual commitment in which they agree to be jointly responsible for each other's common welfare and share financial obligations; (v) are each eighteen (18) years of age or older; (vi) are mentally competent to consent to contract; and (vii) are, and continuously have been for the past twelve (12) months

immediately preceding the date of enrollment of the partner in the Plan, each other's sole domestic partner and are responsible for each other's common welfare.

2.11. Effective Date. "Effective Date" of the Plan means July 1, 2003.

2.12. Eligible Employee. "Eligible Employee" means any Employee, other than an Employee who is a Covered Dependent, who is:

(a) A staff member who works in a position that requires 20 or more hours of work per week and is schedule to work at least 1,000 hours each year;

(b) A tenured or tenure-track faculty member; or

(c) An annually appointed teaching faculty member who teaches at least three courses per academic year and whose annual appointment is for at least two semesters.

An Employee's job position, schedule, title, appointment, or classification shall be determined by the payroll or personnel records maintained by the University and shall be binding and conclusive for all purposes of the Plan.

2.13. Employee. "Employee" means, for purposes of the Plan, any person who is employed by the University; provided, however, that the term "Employee" shall exclude any individual who is not reported as a common law employee by the University as determined by the payroll or personnel records maintained by the University at the time the services were performed, including but not limited to an independent contractor or an individual whose services are performed pursuant to an agreement between the University and any other person including a leasing organization, regardless of the classification of such individual by a regulatory body or court of law. An individual shall not be retroactively deemed an Employee for purposes of the Plan even if a court or other administrative agency determines that such individual is a common law employee for all or any portion of the period such individual was excluded from participation.

2.14. ERISA. "ERISA" means the Employee Retirement Income Security Act of 1974, and the regulations thereunder. Reference to a specific ERISA Section shall be deemed also to refer to any applicable regulations under that Section, and shall also include any comparable provisions of future legislation that amend, supplement, or supersede that specific Section.

2.15. Leave of Absence. "Leave of Absence" shall mean any paid or unpaid personal leave from active employment duly authorized by the University under its leave of absence policy as in effect or amended from time to time. The term "Leave of Absence" shall include the following types of Leaves of Absence unless otherwise provided or if a different meaning is clearly required by the context:

(a) “FMLA Leave of Absence” shall mean any paid or unpaid leave from active employment duly authorized by the University under the Family and Medical Leave Act of 1993.

(b) “Military Leave of Absence” shall mean any paid or unpaid leave from active employment duly authorized by the University for active service in the Armed Forces of the United States (including annual required reserve training) or any other U.S. military service that entitles an Eligible Employee to reemployment rights under the Uniformed Services Employment and Reemployment Rights Act of 1994.

2.16. Open Enrollment Period. “Open Enrollment Period” means (i) the 31-day period (or such other period as may established by the University) following the later of an Eligible Employee’s hire date or the date an Employee becomes an Eligible Employee during which an Eligible Employee may enroll in the Plan and make his or her coverage elections under the Plan or (ii) the enrollment period, established by the University, preceding each Coverage Period during which an Eligible Employee may enroll in the Plan and make his or her coverage elections under the Plan for the next Coverage Period.

2.17. Participant. “Participant” means an Eligible Employee who is properly enrolled in the Plan in accordance with the provisions of Section 3.1.

2.18. Participant Contributions. “Participant Contributions” means the Participant’s cost for his or her enrollment in the Plan. For each Coverage Period or for such periods as the University may determine, the University, in its sole discretion, shall determine for each Participant, the amount of his or her Participant Contributions for each Coverage Option and Coverage Level offered under the Plan and shall communicate the same to such Participant prior to the time he or she makes his or her elections for the Coverage Period. The University may, in its sole discretion, adjust Participant Contributions during a Plan Year, including, but not limited to, increasing Participant Contributions for Continuation Coverage or Retiree enrollment.

2.19. Plan. “Plan” means the William Marsh Rice University Medical Plan, as amended from time to time.

2.20. Plan Administrator. “Plan Administrator” means the person or entity who is authorized to administer the Plan pursuant to Section 8.1. If a Plan Administrator has not been appointed or resigns from a prior appointment, the University shall be deemed to be the Administrator.

2.21. Plan Year. “Plan Year” means the 12-consecutive month period beginning each July 1<sup>st</sup>.

2.22. Retiree. “Retiree” means a former Eligible Employee who meets the requirements set forth in the *Rice University Human Resources Policy No. 422-98* which provisions, as amended from time to time, are incorporated in the Plan by this reference.

2.23. Severance. “Severance” means the termination of an Employee’s employment, in any capacity, with the University, by reason of such Employee’s death, retirement, resignation, discharge, disability or otherwise. For the purpose of determining whether an Employee has incurred a Severance, the following rules shall apply:

(a) An Employee shall not be deemed to have incurred a Severance by reason of his or her absence from employment with the University because of (i) a paid vacation or holiday, or (ii) an approved Leave of Absence (whether paid or unpaid); and

(b) For purposes of the Plan, an Employee shall be deemed to have incurred a Severance on the earlier of the following:

(i) The date on which he or she dies, retires, resigns, is discharged, or terminates employment on account of disability or otherwise with the University; or

(ii) The date on which he or she is scheduled to return to work after the expiration of a Leave of Absence if he or she does not return to work on or before that date.

2.24. Special Enrollment Period. “Special Enrollment Period” means the 31-day period following a special enrollment event described in Section 3.3 during which an Eligible Employee may enroll in the Plan, or a Dependent may be enrolled in the Plan, or a Participant may change his or her Coverage Elections or terminate enrollment in the Plan during a Coverage Period.

2.25. University . “University” means the William Marsh Rice University.

ARTICLE III  
EMPLOYEE ENROLLMENT

3.1 Open Enrollment Periods. An Eligible Employee may elect to enroll in the Plan during an Open Enrollment Period; provided, that the Eligible Employee agrees to pay his or her Participant Contributions for his or her enrollment. Upon enrollment, an Eligible Employee shall become a Participant in the Plan and may enroll a Dependent in the Plan as provided in Section 3.2 below. For subsequent Coverage Periods, a Participant shall enroll in the Plan during the Open Enrollment Period; provided, however, if a Participant fails to return a completed enrollment election to the University during an Open Enrollment Period, the Participant's enrollment election shall continue in effect for the subsequent Coverage Period unless notified otherwise by the University. An enrollment election shall be effective as of (i) the first day of the Coverage Period if enrollment occurs during an Open Enrollment Period preceding that Coverage Period or (ii) the first day of the month coincident with or next following the date a completed enrollment election is submitted to the University if enrollment occurs after the start of a Coverage Period. If an Eligible Employee waives enrollment or fails to submit a completed enrollment election to the University during an Open Enrollment Period, he or she shall not be eligible to enroll in the Plan until the next Open Enrollment Period unless he or she is eligible to enroll during a Special Enrollment Period as provided in Section 3.3.

3.2 Enrollment of Dependents. A Participant may enroll a Dependent(s) in the Plan during an Open Enrollment Period; provided, that the Participant agrees to pay his or her Participant Contributions for the Dependent's enrollment. Upon enrollment, a Dependent shall become a Covered Dependent under the Plan. For subsequent Coverage Periods, a Participant shall enroll a Dependent in the Plan during the Open Enrollment Period; provided, however, if a Participant fails to return a completed enrollment election to the University during an Open Enrollment Period, enrollment for his or her Covered Dependents shall continue in effect for the subsequent Coverage Period unless notified otherwise by the University. An enrollment election for a Dependent shall be effective as of (i) the first day of the Coverage Period if enrollment occurs during an Open Enrollment Period preceding that Coverage Period or (ii) the first day of the month coincident with or next following the date a completed enrollment election is submitted to the University if enrollment occurs after the start of a Coverage Period. If a Participant does not enroll a Dependent during an Open Enrollment Period, the Dependent shall not be eligible to be enrolled in the Plan until the next Open Enrollment Period unless the Participant is eligible to enroll the Dependent during a Special Enrollment Period as provided in Section 3.3.

3.3 Special Enrollment Periods. If an Eligible Employee fails to enroll himself or herself (and any Dependents) in the Plan or if a Participant fails to enroll a Dependent in the Plan during an Open Enrollment Period, such Eligible Employee or Dependent may be enrolled in the Plan after the start of a Coverage Period upon the occurrence of any one of the following special enrollment events:

(a) If an Eligible Employee waived enrollment during an Open Enrollment Period because he or she (and any Dependent) was enrolled under another health plan, the Eligible Employee (and any Dependent) may enroll in the Plan effective as of the first day of the month coincident with or next following the date he or she submits a completed enrollment election to the University; provided, that the Eligible Employee enrolls in the Plan (and enrolls any Dependent) within the Special Enrollment Period following the loss of such other coverage and agrees to pay his or her Participant Contributions for his or her enrollment. This subsection (a), shall only apply to a loss of coverage as described under Code Section 9801(f)(1).

(b) If a Participant did not enroll a Dependent during an Open Enrollment Period because the Dependent was enrolled under another health plan, the Participant may enroll such Dependent in the Plan effective as of the first day of the month coincident with or next following the date a completed enrollment election for the Dependent is submitted to the University; provided, that the Participant enrolls the Dependent in the Plan within the Special Enrollment Period following the loss of such other coverage and agrees to pay his or her Participant Contributions for the Dependent's enrollment. This subsection (b), shall only apply to a loss of coverage as described under Code Section 9801(f)(1).

(c) If a Participant acquires a spouse through marriage or acquires a Domestic Partner, the Participant may enroll such person in the Plan as a Dependent effective as of the first day of the month coincident with or next following the date a completed enrollment election for the Dependent is submitted to the University; provided, that the Participant enrolls the Dependent in the Plan within the Special Enrollment Period following acquisition and agrees to pay his or her Participant Contributions for the Dependent's enrollment.

(d) If a Participant acquires a Dependent through birth, adoption, or placement for adoption, the Participant may enroll such Dependent in the Plan effective as of the date of the event; provided, that the Participant enrolls the Dependent within the Special Enrollment Period following acquisition and agrees to pay his or her Participant Contributions for the Dependent's enrollment.

(e) An Eligible Employee or a Dependent may be enrolled in the Plan after the start of a Coverage Period upon a change in status (or other permitted election change) as defined in Code Section 125 and the regulations thereunder effective as of the first day of the month coincident with or next following the date a completed enrollment election is submitted to the University; provided, that the Eligible Employee enrolls or Dependent is enrolled in the Plan within the Special Enrollment Period following the change of status event and agrees to pay his or her Participant Contributions for the enrollment. An enrollment election shall be permitted under this subsection only if the enrollment election is on account of and corresponds to the change in status event permitting the election change. It is intended that the Special Enrollment Period be permitted herein only if consistent with the requirements of Code Section 125 and the regulations thereunder; provided, however, if the Plan Administrator determines that an

enrollment election is not permitted under Code Section 125 and the regulations thereunder, such determination shall be binding and conclusive on any Eligible Employee, Participant or Dependent.

If an Eligible Employee fails to enroll in the Plan or if a Dependent is not enrolled in the Plan during the Special Enrollment Period, the Eligible Employee or Dependent shall not be eligible to enroll in the Plan until the next Open Enrollment Period unless another special enrollment event as provided in this Section 3.3 would otherwise permit enrollment.

3.4 Coverage Elections. An Eligible Employee who enrolls in the Plan shall elect a Coverage Option and Coverage Level for the Coverage Period or the remainder of the Coverage Period. For subsequent Coverage Periods, a Participant shall elect a Coverage Option and Coverage Level during the Open Enrollment Period; provided, that if a Participant fails to return a completed enrollment election to the University during an Open Enrollment Period, the Participant shall be deemed to have elected the same Coverage Elections in effect as of the last day of the preceding Coverage Period unless the Coverage Option and/or Coverage Level elected is no longer offered under the Plan. A Participant may change his or her Coverage Elections during a Coverage Period upon the occurrence of a special enrollment or change in status event described in Section 3.3 effective as of the first day of the month coincident with or next following the date a completed enrollment election is submitted to the University; provided, that the new Coverage Elections correspond to the special enrollment or change in status event and a new enrollment election is submitted to the University within the Special Enrollment Period following the special enrollment event and agrees to pay his or her Participant Contributions for the enrollment based on the new Coverage Elections.

3.5 Participant Election to Terminate Enrollment. A Participant may terminate his or her enrollment and the enrollment of any Covered Dependent upon the occurrence of a special enrollment event described in Section 3.3(e) pertaining to change in status events, effective as of the first day of the month coincident with or next following the date a completed enrollment election is submitted to the University; provided, that a new enrollment election is submitted within the Special Enrollment Period following the special enrollment event.

3.6 Participation during Leave of Absence. A Participant and any Covered Dependent shall continue or shall be eligible to continue participation in the Plan during a Leave of Absence as set forth below:

(a) A Participant and any Covered Dependent shall continue to participate in the Plan during a paid Leave of Absence as if the Participant was actively employed by the University and the Participant's enrollment election shall continue in effect for the remainder of the Coverage Period unless another special enrollment event as described in Section 3.3 (other than the Leave) would otherwise permit the Participant to change his or her enrollment election. For subsequent Coverage Periods, a Participant shall be eligible to enroll in the Plan and enroll any Dependent in the Plan as provided under Sections 3.1 and 3.2, respectively.

(b) A Participant and any Covered Dependent shall continue to participate in the Plan during an unpaid Leave of Absence and may make a one-time election to continue enrollment in the Plan; provided, that (i) the Participant files an election to continue enrollment in the Plan with the University prior to the Leave and (ii) the Participant agrees to pay his or her Participant Contributions for continued enrollment in the Plan in such amounts as determined by the University under such methods as established by the University. If a Participant elects to continue enrollment in the Plan, his or her enrollment election shall continue in effect for the remainder of the Coverage Period unless another special enrollment event as described in Section 3.3 (other than the Leave) would otherwise permit the Participant to change his or her enrollment election. For subsequent Coverage Periods, a Participant shall be eligible to enroll in the Plan and enroll any Dependent in the Plan as provided under Sections 3.1 and 3.2, respectively. If a Participant fails to remit his or her Participant Contributions when due, his or her enrollment in the Plan shall terminate as of the last day of the period for which the last payment of Participant Contributions was due.

(c) A Participant may terminate his or her enrollment and any Covered Dependents enrollment during an unpaid Leave of Absence. Upon such election, the Participant's enrollment in Plan shall be suspended as of date his or her Leave begins and shall terminate at the end of the Coverage Period in which the Leave begins unless active participation is reinstated earlier as provided in subsection (d) below.

(d) If a Participant returns from an unpaid Leave of Absence within 31 days after his or her Leave begins and before the end of the Coverage Period in which his or her Leave begins, the Participant's most recent enrollment election shall be reinstated for the remainder of the Coverage Period unless another special enrollment event as described in Section 3.3 (other than the Leave) would otherwise permit the Participant to change his or her enrollment election. If a Participant returns from an unpaid Leave of Absence more than 31 days after his or her Leave begins or after the end of the Coverage Period in which his or her Leave begins, his or her enrollment election shall not be reinstated and the Participant shall be eligible to enroll in the Plan and enroll any Dependent in the Plan as provided under Sections 3.1 and 3.2, respectively.

3.7 Suspension of Participation. A Participant and his or her Covered Dependents shall be suspended from participating in the Plan as of the earlier of: (i) the date the Participant ceases to be an Eligible Employee but does not incur a Severance or (ii) the date the Plan is amended to terminate participation with respect to a class of Employees of which the Participant is a member, as set forth below:

(a) If a Participant's enrollment in the Plan is suspended, the Participant's enrollment election shall be suspended and shall terminate at the end of the Coverage Period in which the suspension occurs unless active participation is reinstated earlier as provided in subsection (c) below.

(b) Notwithstanding subsection (a), a Participant may continue his or her enrollment in the Plan (and the enrollment of any Covered Dependent) if he or she is

eligible for and elects Continuation Coverage; provided, that Participant agrees to pay his or her Participant Contributions for continued enrollment in the Plan in such amounts as determined by the University on the same schedule that his or her Participant Contributions would have paid if the Participant was not suspended. If a Participant fails to remit his or her Participant Contributions when due, his or her enrollment in the Plan shall terminate as of the last day of the period for which the last payment of Participant Contributions was due.

(c) If a suspended Participant becomes eligible to resume active participation in the Plan within 31 days after his or her suspension and before the end of the Coverage Period in which his or her suspension occurs, the Participant's most recent enrollment election shall be reinstated unless another special enrollment event as described in Section 3.3 (other than the cause of the initial suspension) would otherwise permit the Participant to change his or her enrollment election. If a suspended Participant becomes eligible to resume active participation in the Plan more than 31 days after his or her suspension or after the end of the Coverage Period in which his or her suspension occurs, his or her enrollment election shall not be reinstated and the Participant shall be eligible to enroll in the Plan and enroll any Dependent in the Plan as provided under Sections 3.1 and 3.2, respectively.

3.8 Termination of Enrollment – Participant. Unless a Participant is eligible for extended enrollment as provided in Section 3.11, a Participant shall cease to be a Participant under the Plan as of the earliest of:

- (a) the date of termination of the Plan;
- (b) the last day of the 31-day period following the date advance written notice of termination of enrollment is provided to the Participant for his or her failure to make his or her Participant Contributions when due;
- (c) the date the Participant elects to termination enrollment as provided in Sections 3.5 and 3.6 subject to the reinstatement provisions of Section 3.6;
- (d) the date the Participant ceases to be an Eligible Employee without incurring a Severance subject to the reinstatement provisions of Section 3.7;
- (e) the date the Plan is amended to terminate enrollment in the Plan with respect to a class of Employees or former Employees of which the Participant is a member subject to the reinstatement provisions of Section 3.7; or
- (f) the last day of the month in which the Participant incurs a Severance; provided, however, if a former Participant is rehired within 31 days after his or her Severance and before the end of the Coverage Period in which his or her Severance occurs, the Participant's most recent enrollment election shall be reinstated unless another special enrollment event as described in Section 3.3 (other than the Severance) would otherwise permit the Participant to change his or her enrollment election.

Once enrollment is terminated under this Section, no further benefits shall be provided by the Plan to the Participant.

3.9 Termination of Enrollment – Covered Dependent. Unless a Covered Dependent is eligible for extended enrollment as provided in Section 3.11, a Covered Dependent shall cease to be a Covered Dependent under the Plan as of the earliest of:

(a) the date a Participant's enrollment terminates in the Plan (with respect to whom the Covered Dependent is entitled to coverage) subject to the reinstatement provisions of Sections 3.7, and 3.8;

(b) the last day of the 31-day period following the date advance written notice of termination of enrollment is provided to the Participant (with respect to whom the Covered Dependent is entitled to coverage) for his or her failure to make his or her Participant Contributions for the Covered Dependent when due;

(c) the date the Participant elects to termination enrollment for the Covered Dependent as provided in Sections 3.5 and 3.6 subject to the reinstatement provisions of Section 3.6; or

(d) the date on which a Covered Dependent ceases to satisfy the definition of Dependent as set forth in Article II; provided, however, enrollment of a child who is a Covered Dependent shall not cease until the end of the month during which such child reaches a limiting age.

Once enrollment is terminated under this Section, no further benefits shall be provided by the Plan to the Covered Dependent.

3.10 Termination of Enrollment for Cause. A Participant and/or Covered Dependent's enrollment in the Plan may be terminated for cause as of the earliest of:

(a) the date enrollment commenced if enrollment commenced as a result of the Participant willfully providing incorrect or incomplete information in a statement made for the purpose of enrolling in the Plan and enrollment would have been denied if accurate information had been provided;

(b) the last day of the 31-day period following the date advance written notice of termination of enrollment is provided to the Participant for his or her refusal (or the refusal of his or her Covered Dependent) to cooperate and provide any facts necessary for the Plan Administrator or its delegate to administer the Plan's coordination of benefits provisions; or

(c) the date a Participant or his or her Covered Dependent willfully furnishes incorrect or incomplete information in a statement made for the purpose of obtaining

benefits from the Plan, including but not limited to, permitting a person who is not a Participant or Covered Dependent access to participant identification cards.

Once enrollment is terminated under this Section, no further benefits shall be provided by the Plan to the Participant and/or Covered Dependent. Any termination for cause is subject to review by the Plan Administrator in accordance with the Plan's review procedures for eligibility determination as set forth in Section 7.5. A Participant may request that such review be conducted within 15 business days after receiving notice that enrollment has been or will be terminated. Termination of enrollment may be retroactive to the original date of termination if the final decision is in favor of the Plan.

3.11 Extended Enrollment. Notwithstanding Sections 3.8 and 3.9, a Participant may extend his or her enrollment and the enrollment of a Covered Dependent in the Plan under election procedures established by the University as follows:

(a) Continuation Coverage. A Qualified Beneficiary (as defined in Article V) whose enrollment would otherwise terminate under the Plan may elect Continuation Coverage as provided under Article V at the Coverage Option in effect at the time of his or her Severance upon the occurrence of a Qualifying Event (as defined in Article V).

(b) Retirees. A Participant who is a Retiree may make a one-time election at the time of his or her Severance to extend enrollment in the Plan as provided under Article IV.

3.12 Certification of Coverage. The University shall provide a certification of coverage to a Participant and/or Covered Dependent confirming participation in the Plan upon termination of participation in the Plan.

3.13 Access to Employee Assistance Benefits. Notwithstanding anything in the Plan to the contrary, all Employees of the University shall have access to employee assistance benefits as described in Appendix E.

ARTICLE IV  
RETIREE ENROLLMENT

4.1. Initial Enrollment of Retiree. A Retiree shall be eligible to make a one-time election to continue enrollment in the Plan following his or her Severance; provided, that (i) the Retiree is a Participant at the time of the Retiree's Severance, (ii) the Retiree waives all rights to the Continuation Coverage except to the extent provided in Section 4.8, and (iii) the Retiree agrees to pay his or her Participant Contributions for enrollment at such times and in such amounts as determined by the University.

4.2. Initial Enrollment of Dependents. A Retiree shall be eligible to make a one-time election to continue enrollment for any Dependent under the Plan at the same time the Retiree elects to continue enrollment under the Plan; provided, that (i) the Dependent is a Covered Dependent at the time of the Retiree's Severance, (ii) the Dependent waives all rights to the Continuation Coverage except to the extent provided in Section 4.8, and (iii) the Retiree agrees to pay his or her Participant Contributions for such Covered Dependent's enrollment at such times and in such amounts as determined by the University.

4.3. Retiree Enrollment Period. A Retiree must file an election to continue enrollment in the Plan with the University within the 31-day period following a Retiree's Severance. A Retiree shall receive enrollment forms from the University prior to the time of his or her Severance.

4.4. Failure to Elect Continued Enrollment. If a Retiree fails to return a completed enrollment form to the University within the Retiree enrollment period described in Section 4.3 above, he or she shall no longer be eligible to enroll in the Plan as a Retiree. However, the Retiree and any Dependent who is a Covered Dependent at the time of the Retiree's Severance shall be eligible to elect Continuation Coverage.

4.5. Coverage Elections. A Retiree, upon his or her election to continue enrollment in the Plan, shall continue enrollment in the Plan in the same manner as if he or she were Participant in the Plan except as set forth below:

- (a) Enrollment of Dependents shall be limited to Dependents who are properly enrolled in the Plan as provided under Section 4.2.
- (b) Benefits provided under the Plan shall be integrated with Medicare in accordance with the provisions of the applicable Summary of Coverage.

4.6. Termination of Enrollment - Retiree. Unless a Retiree is eligible for Continuation Coverage as provided in Section 4.8, a Retiree shall cease to be a Participant under the Plan as of the earliest of:

- (a) the date of termination of the Plan;

(b) the date the Plan is amended to terminate enrollment under the Plan with respect to a class of former Employees of which the Retiree is a member;

(c) the date on which the Retiree cancels or terminates his or her enrollment in the Plan.

(d) the last day of the 31-day period following the date advance written notice of termination of enrollment is provided to the Retiree for his or her failure to make his or her Participant Contributions when due; or

(e) the date enrollment is terminated for cause as provided in Section 3.10.

If enrollment ceases under this Section, a Retiree may not reinstate his or her enrollment at a later date.

4.7. Termination of Enrollment – Covered Dependent. Unless a Covered Dependent is eligible for Continuation Coverage as provided in Section 4.8, a Covered Dependent shall cease to be a Covered Dependent under the Plan as of the earliest of:

(a) the date a Retiree's enrollment terminates in the Program (with respect to whom the Covered Dependent is entitled to coverage) except that in the event of a Retiree's death, his or her Covered Dependents may continue enrollment under the same terms and conditions that were applicable before the Retiree's death;

(b) the date on which the Retiree cancels or terminates the Covered Dependent's enrollment in the Plan or, after the death of a Retiree, the date on which a Covered Dependent elects to cancel or terminate his or her enrollment in the Plan or enrolls in another group health plan;

(c) the date on which a Covered Dependent ceases to satisfy the definition of Dependent as set forth in Article II; provided, however, enrollment of a child who is a Dependent shall not cease until the end of the month during which such child reaches a limiting age;

(d) the last day of the 31-day period following the date advance written notice of termination of enrollment is provided to the Participant (with respect to whom the Covered Dependent is entitled to coverage) for his or her failure to make his or her Participant Contributions for the Covered Dependent when due; or

(e) the date enrollment is terminated for cause as provided in Section 3.10.

If enrollment ceases under this Section, a Covered Dependent's enrollment may not be reinstated at a later date.

4.8. Continuation Coverage. If a Retiree or Covered Dependent enrollment in the Plan ceases under Section 4.6 or Section 4.7, respectively, and such Retiree or Covered Dependent is

a Qualified Beneficiary (as defined in Article V), he or she may elect Continuation Coverage as provided under Article V at the Coverage Option in effect at the time his or her enrollment would have ceased but for this Section, provided, however, that notwithstanding anything to the contrary in Article V, the Period of Continuation Coverage (as defined in Article V) shall be reduced by the number of months the Retiree or Covered Dependent is enrolled in the Plan under this Article IV or to the extent permitted under the Code, ERISA or other applicable law unless determined otherwise by the University.

4.9. Review Procedures for Eligibility Determination. If a former Employee has not filed a claim for benefits and has not been issued a Notice of Denial pursuant to Section 7.3 but believes that he or she is being denied his or her status as a Retiree and/or believes that he or she is being denied rights as to his or her eligibility to continue enrollment under this Article IV, such former Employee shall follow the administrative procedures for review as set forth in Section 7.5.

4.10. Amendment or Termination of Retiree Enrollment. The University shall have the right at any time and for any or no reason to amend the provisions for Retiree enrollment under the Plan, including but not limited to, amending the Plan to terminate participation with respect to a class of Retirees of which the Retiree is a member or to terminate future participation with respect to a class of Participants or Eligible Employees of which the Participant or Eligible Employee is a member. The University shall also have the right at any time and for any or no reason to terminate Retiree enrollment in its entirety under the Plan.

ARTICLE V  
CONTINUATION COVERAGE

5.1. In General. Notwithstanding any other provision in the Plan to the contrary, any Qualified Beneficiary who would otherwise lose coverage as a result of a Qualifying Event shall have the right to elect Continuation Coverage under the Plan, provided, that an election to continue enrollment is made within the applicable Election Period. Such Continuation Coverage shall continue for the period set forth in Section 5.3 below. The Qualified Beneficiary shall pay the cost of such Continuation Coverage, which shall be computed by the University in accordance with the provisions of Section 5.4 below.

5.2. Special Definitions. For purposes of this Article, the following words or phrases shall have the meaning set forth below unless the contrary is clearly indicated:

(a) Continuation Coverage. “Continuation Coverage” shall mean that coverage (as is defined in ERISA Section 602(1) and Code Section 4980B(f)(2)(A)) identical to the coverage being provided under the Plan to similarly situated Participants with coverage at the same Coverage Option with respect to whom a Qualifying Event has not occurred. If coverage under the Plan is modified for any group of Participants, Continuation Coverage shall also be modified in the same manner for all Qualified Beneficiaries under the Plan who are similarly situated with respect to such group.

(b) Election Period. “Election Period” shall mean the period during which a Qualified Beneficiary may elect Continuation Coverage. Such period shall begin on the date on which regular enrollment under the Plan terminates by reason of a Qualifying Event and shall end on the date which is 60 days after the later of (i) the date on which regular enrollment under the Plan terminates by reason of a Qualifying Event, or (ii) in the case of a Qualified Beneficiary who is entitled to receive notice of a Qualifying Event triggering Continuation Coverage from the Plan Administrator, the date of the Qualified Beneficiary’s receipt of such notice.

(c) Group Health Plan. “Group Health Plan” shall mean any plan (including a self-insured plan) of, or contributed to by, the University to provide health care (as defined in Code Section 213(d)) to its Employees, former employees, others associated or formerly associated with the University in a business relationship or their families directly or through insurance, reimbursement or otherwise. Such term shall not include any plan under which substantially all of the coverage is for qualified long-term care services as defined in Code Section 7702B(c).

(d) Qualified Beneficiary. “Qualified Beneficiary” shall mean a Dependent of the Participant who is a Covered Dependent on the day before the Qualifying Event and any child who is born to or placed for adoption with such Participant during a period of Continuation Coverage. Such term shall also mean a Participant, but only if such Participant incurs a Termination of Employment or a reduction in hours of employment resulting in termination of enrollment in the Plan. In the case of multiple Qualifying Events, the status of an individual as a Qualified Beneficiary shall be determined on the

day before the occurrence of the earliest Qualifying Event. Solely in the case of a Qualifying Event described in paragraph (e)(vi), a Qualified Beneficiary shall mean a Participant who has retired on or before the date of substantial elimination of coverage and any other individual who, on the day before the Qualifying Event, is a Covered Dependent under the Plan by reason of his or her status as such Participant's spouse, surviving spouse, or dependent child. Notwithstanding the foregoing, an individual shall not be considered a Qualified Beneficiary if:

(i) The individual (other than a child who is born to or placed for adoption with a Participant during a period of Continuation Coverage) is not enrolled in the Plan on the day before the Qualifying Event. The reason for the individual's lack of actual enrollment (such as the individual's having declined enrollment in the Plan or failed to satisfy the Plan's eligibility requirements) is not relevant for this paragraph;

(ii) The individual is an Employee or former Employee and his or her status as a Participant is attributable to a period in which such Employee was a nonresident alien who received no earned income (within the meaning of Code Section 911(d)(2)) from the University which constituted income from sources within the United States (within the meaning of Code Section 861(a)(3)) on the day before the Qualifying Event. If, pursuant to the preceding sentence, an individual is not a Qualified Beneficiary, then a spouse or dependent child of the individual is not considered a Qualified Beneficiary by virtue of the relationship to the individual;

(iii) The individual is covered under the Plan by reason of another individual's election of Continuation Coverage on the day before the Qualifying Event and is not already a Qualified Beneficiary by reason of a prior Qualifying Event;

(iv) The individual is entitled to benefits under Title XVIII of the Social Security Act on the day before the Qualifying Event; or

(v) The individual has previously waived Continuation Coverage in connection with a prior Qualifying Event.

(e) Qualifying Event. "Qualifying Event" shall mean an event that would normally result in a Qualified Beneficiary's loss of coverage under the Plan if Continuation Coverage were not offered. Qualifying Events under the Plan shall include:

(i) The death of a Participant;

(ii) A Participant's Termination of Employment or reduction of hours of employment resulting in termination of enrollment under the Plan;

(iii) The divorce or legal separation of a Participant from his or her spouse;

(iv) A Participant's entitlement to benefits under Title XVIII of the Social Security Act;

(v) The cessation of enrollment for a Covered Dependent under the terms of the Plan; or

(vi) The commencement of a proceeding in a case under Title 11, United States Code, with respect to the University from whose employment a Participant retired at any time. In the case of this Qualifying Event only, a loss of coverage includes a substantial elimination of coverage with respect to a Qualified Beneficiary within one year before or after the date of commencement of the proceeding.

(f) Termination of Employment. "Termination of Employment" shall mean the Participant's termination of employment with the University, provided, however, such termination is not a result of such Participant's gross misconduct within the meaning of ERISA Section 603(2) and Code Section 4980B(f)(3)(B).

5.3. Period of Continuation Coverage. Each Qualified Beneficiary who loses coverage under the Plan as a result of a Qualifying Event may elect during the Election Period to continue his or her enrollment under the Plan from the date of the Qualifying Event to the earliest of the dates described in subsections (a) through (f):

(a) The date that is the earlier of whichever of the following dates, is applicable:

(i) In the case of a Qualifying Event described in Section 5.2(e)(ii), the date which is 18 months after the date of such Qualifying Event;

(ii) In the case of a Qualifying Event described in Section 5.2(e)(ii), the date which is 29 months after the date of such Qualifying Event if a Qualified Beneficiary is determined to be disabled under Title II or Title XVI of the Social Security Act during the first 60 days of Continuation Coverage and such Qualified Beneficiary notifies the Plan Administrator of such determination both within 60 days after the date the determination is issued and before the end of the first 18 months of Continuation Coverage;

(iii) In the case of a second Qualifying Event (other than a Qualifying Event described in Section 5.2(e)(vi)) which occurs during the 18 month period (29 month period in the case of a Qualified Beneficiary who is entitled to extended disability Continuation Coverage for disability as provided in paragraph (ii) above) after the date of a Qualifying Event described in

Section 5.2(e)(ii), the date which is 36 months after the date of a Qualifying Event described in Section 5.2(e)(ii);

(iv) In the case of a Qualifying Event under Section 5.2(e)(vi), the date of the death of the Participant, or in the case of a spouse or dependent children of a Participant, the date which is 36 months after such Participant's death;

(v) In the case of a Qualifying Event other than an event described in Section 5.2(e)(ii) or Section 5.2(e)(vi), the date which is 36 months after the date of the Qualifying Event; or

(vi) In the case of a Qualifying Event under Section 5.2(e)(ii) that occurs less than 18 months after the date the Participant becomes entitled to benefits under Title XVIII of the Social Security Act, the period of coverage for Qualified Beneficiaries other than the Participant is the date which is 36 months after the date the Participant becomes entitled to benefits under Title XVIII of the Social Security Act.

(b) The date on which coverage ceases under the Plan by reason of the Qualified Beneficiary failing to make his or her Participant Contributions within 30 days after the date due; provided, however, if Continuation Coverage is elected, Participant Contributions for coverage during the period preceding such election shall be considered timely if made within 45 days after the date of such election.

(c) The date on which the University ceases to provide coverage under the Plan.

(d) The date on which the Qualified Beneficiary first becomes covered under any other Group Health Plan as an employee or otherwise under any other Group Health Plan which does not contain an exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary (other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary by reason of the provisions in Code Section 9801 (relating to limitations on pre-existing condition exclusion periods in group health plans).

(e) The date on which the Qualified Beneficiary first becomes entitled to benefits under Title XVIII of the Social Security Act.

(f) The month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that a Qualified Beneficiary is no longer disabled in the case of a Qualified Beneficiary who is on extended disability Continuation Coverage as provided in paragraph (a)(ii) above.

(g) The date coverage is terminated for cause pursuant to Section 3.10.

5.4. Cost of Continuation Coverage. The Participant Contributions payable by a Qualified Beneficiary for Continuation Coverage shall be equal to 102% (150% after the initial 18 month period if a Qualified Beneficiary is entitled to extended disability Continuation Coverage as provided in Section 5.3(a)(ii)) of a reasonable estimate of the cost of providing coverage for a similarly situated Participants. The Plan Administrator shall determine such cost on an actuarial basis in accordance with applicable regulations before the beginning of each Coverage Period. Alternatively, the Plan Administrator may determine the Participant Contributions for Continuation Coverage as 102% (150% after the initial 18 month period if a Qualified Beneficiary is entitled to extended disability Continuation Coverage as provided in Section 5.3(a)(ii)) of the cost of coverage for a similarly situated Participants for the preceding Coverage Period, adjusted to reflect cost of living increases as measured by the “implicit price deflator of the gross national product,” as defined in ERISA Section 604(2) and Code Section 4980B(f)(4)(B) unless there has been a significant change affecting the cost of coverage under the Plan.

5.5. Election Procedures for Continuation Coverage. In order for a Continuation Coverage election to be effective, such election shall be made before the expiration of the Election Period. In the case of a Qualified Beneficiary who is either a Participant or the spouse of a Participant, any election of Continuation Coverage by such Qualified Beneficiary shall be deemed to include an election of Continuation Coverage on behalf of any other Qualified Beneficiary who would lose coverage under the Plan by reason of the same Qualifying Event except as otherwise specified in the election. Each Qualified Beneficiary shall be entitled to make a separate selection among types of coverage provided under the Plan but only to the extent required by the Code or ERISA. The Participant Contributions payable by the Qualified Beneficiary shall be made in advance in monthly payments unless the Qualified Beneficiary elects to make advance annual payments. If an election for Continuation Coverage is made after the occurrence of a Qualifying Event, payment for such Continuation Coverage for the period preceding the election shall be made within 45 days after the date of the election.

5.6. Notice for Qualifying Events.

(a) Upon the occurrence of a Qualifying Event described in Section 5.2(e)(i), (ii), (iv) or (vi), the University shall notify the Plan Administrator of such Qualifying Event within 30 days after the date of the Qualifying Event. The Plan Administrator shall in turn notify any Qualified Beneficiaries of their rights to Continuation Coverage under the Plan within 14 days after the Plan Administrator receives notification from the Plan of the Qualifying Event.

(b) Upon the occurrence of a Qualifying Event described in Section 5.2(e)(iii) or (v), either the Participant or the affected Qualified Beneficiary shall notify the Plan Administrator of such Qualifying Event. If the Plan Administrator is not so notified within 60 days after the later of (i) the date of the Qualifying Event, or (ii) the date that the Qualified Beneficiary would lose coverage on account of the Qualifying Event, the Plan may, but shall not be required, to offer the Qualified Beneficiary an opportunity to elect Continuation Coverage. If the Participant notifies the Plan Administrator of a Qualifying Event described in this subsection (b), the Plan Administrator shall notify any

Qualified Beneficiaries of their rights to Continuation Coverage within 14 days after the Plan Administrator receives notification from the Participant.

(c) Any notice required to be given by the Plan Administrator to a Qualified Beneficiary who is the spouse of a Participant shall be treated as notice to all other Qualified Beneficiaries residing with such spouse at the time such notice is given.

(d) Notice to a Qualified Beneficiary of his or her Continuation Coverage rights under this Section 5.5 shall be given by first class mail to the last known address of such Qualified Beneficiary.

5.7. Notice of Continuation Coverage Termination Events. Any Qualified Beneficiary for whom Continuation Coverage is in effect shall notify the Plan Administrator immediately if any event described in Section 5.3(d) and (e) occurs with respect to such individual.

5.8. Application of Participant Contributions. The first payment of any Participant Contributions for Continuation Coverage shall be applied to the period of coverage beginning immediately after the date that coverage under the Plan would have been lost on account of the Qualifying Event.

5.9. Enrollment of Additional Dependents. A Qualified Beneficiary who has elected Continuation Coverage may subsequently elect to enroll his or her dependents who join the Qualified Beneficiary's family on or after the Qualified Beneficiary's Qualifying Event in the same manner that a Participant may enroll his or her Dependents pursuant to Section 3.2; provided, however, such Qualified Beneficiary makes sufficient contributions to cover the full cost of such coverage as provided by Section 5.4. Such coverage shall terminate on the earlier of (i) the date on which Continuation Coverage terminates for the Qualified Beneficiary under this Article V, or (ii) the date on which the dependent ceases to satisfy the requirements for "Dependent" status as set forth in Article II applied as if the Qualified Beneficiary were a Participant of the University.

5.10. Open Enrollment Period. A Qualified Beneficiary who has elected Continuation Coverage shall have the same rights during an Open Enrollment Period provided to all similarly situated Participants including those rights set forth in Article III regarding enrollment of additional Dependents and changes in Coverage Options. The coverage of any dependents of a Qualified Beneficiary enrolled during an Open Enrollment Period under this Section shall terminate on the earlier of (i) the date on which Continuation Coverage terminates for the Qualified Beneficiary under this Article V, or (ii) the date on which the dependent ceases to satisfy the requirements for "Dependent" status as set forth in Article II applied as if the Qualified Beneficiary were a Participant of the University.

5.11. Incorporation by Reference. The provisions of Part 6 of Subtitle B of ERISA (Sections 601 through 608) and Code Section 4980B(f) and (g) and the regulations thereunder, as amended from time to time, are hereby incorporated by this reference and are applicable to the Plan when such provisions are determined to be applicable under the effective date provisions of ERISA and the Code. To the extent there is conflict between the Plan, its Summary Plan

Description, or any other employee communication, the provisions of ERISA and the Code and the regulations thereunder shall govern.

ARTICLE VI  
COVERAGE ELECTIONS

6.1. Coverage Options. Benefits under the Plan shall be provided under one or more Coverage Options. The Coverage Options available under the Plan are as follows:

(a) RiceCare HMO. The types and amounts of benefits offered under the RiceCare HMO, including but not limited to, any conditions, limitations, exclusions, or coordination of benefits regarding coverage and benefits, are set forth in the RiceCare HMO Summary of Coverage which is attached hereto as Appendix A.

(b) RiceCare POS Plan. The types and amounts of benefits offered under the RiceCare POS Plan, including but not limited to, any conditions, limitations, exclusions, or coordination of benefits regarding coverage and benefits, are set forth in the RiceCare POS Plan Summary of Coverage which is attached hereto as Appendix B. The RiceCare POS Plan shall also be referred to as the “RiceCare Flexplan” or the “RiceCare Flexplan (POS).”

(c) RiceCare PPO. The types and amounts of benefits offered under the RiceCare PPO, including but not limited to, any conditions, limitations, exclusions, or coordination of benefits regarding coverage and benefits, are set forth in the RiceCare PPO Summary of Coverage which is attached hereto as Appendix C.

(d) RiceCare Catastrophic Plan. The types and amounts of benefits offered under the RiceCare Catastrophic Plan, including but not limited to, any conditions, limitations, exclusions, or coordination of benefits regarding coverage and benefits, are set forth in the RiceCare Catastrophic Plan Summary of Coverage which is attached hereto as Appendix D.

Benefits under each Coverage Option listed above include employee assistance benefits as set forth in the Rice Employee Assistance Plan Summary of Coverage which is attached hereto as Appendix E. The foregoing list of Coverage Options is not intended to limit the subsequent addition, amendment, or termination of a Coverage Option under the Plan.

6.2. Coverage Levels. The Coverage Levels available under the Coverage Options are as follows:

- (a) Employee only.
- (b) Employee plus Spouse/Domestic Partner.
- (c) Employee plus child(ren).
- (d) Employee plus family.

The foregoing list of Coverage Levels is not intended to limit the subsequent addition or elimination of a Coverage Level under a Coverage Option.

6.3. Addition, Amendment or Termination of a Coverage Option. The University shall have the right at any time to add, amend or terminate for any or no reason a Coverage Option under the Plan without written notice to Participants or Employees. For the purpose of this Section: (i) if a Coverage Option is added, then a Summary of Coverage shall be attached as an appendix to the Plan and its provisions shall be incorporated in the Plan by this reference, (ii) if a Coverage Option is amended, then an amended Summary of Coverage shall be attached hereto as an appendix and its provisions shall be incorporated in the Plan by this reference, and (iii) if a Coverage Option is no longer reflected in the University's *Benefits Booklet* for a Plan Year, then such Coverage Option shall be deemed terminated effective as of the last day of the Plan Year preceding such Plan Year unless a different termination effective date is reflected in a written amendment to the Plan.

6.4. Addition or Elimination of a Coverage Level. The University shall have the right at any time to add or eliminate for any or no reason a Coverage Level under a Coverage Option without written notice to Participants or Employees. For the purpose of this Section: (i) if a Coverage Level for a Coverage Option is reflected in the University's *Benefits Booklet* for a Plan Year, then such Coverage Level is hereby incorporated in the Plan by this reference and (ii) if a Coverage Level is no longer reflected in the University's *Benefits Booklet* for a Plan Year, then such Coverage Level shall be deemed eliminated effective as of the last day of the Plan Year preceding such Plan Year unless a different elimination date is reflected in a written amendment to the Plan.

6.5. Controlling Effect of a Summary of Coverage. A Summary of Coverage, as in effect or amended from time to time, shall govern the types and amounts of benefits and any conditions or limitations regarding coverage and benefits offered under a Coverage Option. To the extent there is conflict between the Plan and a Summary of Coverage, the Summary of Coverage, as in effect or amended from time to time, shall govern.

ARTICLE VII  
CLAIMS AND APPEALS PROCEDURES

7.1. Submission of Claims and Appeals to Claims Administrator. The Plan Administrator may, in accordance with Section 8.2(i), appoint and designate a Claims Administrator as the named fiduciary with respect to all or part of the claims and appeals procedures set forth in Sections 7.3, 7.4, and 7.5 or may delegate to such Claims Administrator certain responsibilities with respect to all or part of the claims and appeals procedures set forth in Sections 7.3, 7.4, and 7.5. In the event of such appointment and delegation, the term “Claims Administrator” shall be substituted for “Plan Administrator” in each place it appears in Sections 7.3, 7.4, and 7.5 to the extent such appointment and delegation is applicable and the claims and appeals procedures of the Claims Administrator (which shall comply with ERISA) shall govern and supercede the provisions of Sections 7.3, 7.4, and 7.5 and are incorporated in the Plan by this reference.

7.2. Claim for Benefits. A written claim for benefits shall be filed with the Plan Administrator within 12 months (or such other period of time that the Plan Administrator may establish from time to time) following the date the service is rendered or received on such forms as prescribed by the Plan Administrator and under such procedures as established by the Plan Administrator. Failure to file an application for benefits within the required 12-month period shall invalidate in full any claim to such benefits except to the extent that the person applying for benefits under the Plan can demonstrate to the Plan Administrator, (whose determination shall be final and conclusive) that it was not reasonably possible to file such application and that such application shall be filed as soon as reasonably possible. Persons applying for benefits under the Plan shall cooperate with the Plan Administrator and provide any and all information necessary to implement the provisions of the Plan.

7.3. Claims Procedures. A Claimant shall follow the administrative procedures for filing a claim for benefits as set forth in this Section and shall exhaust such administrative procedures prior to seeking an appeal in accordance with Section 7.4. Claims shall be reviewed in accordance with the procedures either approved or established by the Plan Administrator (or its delegate) subject to the following administrative procedures set forth in this Section.

(a) A Claimant must file a claim for benefits with the Plan Administrator within 12 months (or such other period of time that the Plan Administrator may establish from time to time) following the date the service is rendered or received.

(b) The Claimant’s claim must be made in writing and shall include such information as is required by the Plan Administrator. Notwithstanding the foregoing, in the case of an Urgent Care Claim, the Claimant may submit such claim orally or in writing and all necessary information may be transmitted between the Plan Administrator and the Claimant by telephone, facsimile, or other available similarly expeditious method.

(c) The Plan Administrator shall notify a Claimant of its determination as follows:

(i) Upon the initial filing of a Health Claim that is an Urgent Care Claim, the Plan Administrator shall notify the Claimant within 24 hours after receipt of an Urgent Care Claim if the Claimant failed to follow the procedures for filing an Urgent Care Claim (and shall provide the proper procedures to be followed) or if the Urgent Care Claim is missing any information necessary to determine whether, or to what extent, benefits are covered or payable under the Plan. The Plan Administrator shall notify the Claimant of its determination (whether adverse or not) by issuing, as applicable, a Notice of Denial or a notice of complete grant, as expeditiously as possible, but not later than 72 hours after receipt of the Urgent Care Claim by the Plan Administrator or, in the case of an Urgent Care Claim that is incomplete upon initial filing, not later than 48 hours after the earlier of (i) the Plan Administrator's receipt of the missing information, or (ii) the end of the period afforded to the Claimant to provide missing information. The Claimant shall be afforded a reasonable period of time, taking into account the circumstances, but not less than 48 hours, to provide the missing information.

(ii) Upon the initial filing of a Health Claim that is an Urgent Care Claim to request an extension of benefits for additional treatments that have been previously approved, the Plan Administrator shall notify the Claimant of its determination (whether adverse or not) by issuing, as applicable, a Notice of Denial or a notice of complete grant, as expeditiously as possible, within 24 hours after receipt of the request; provided, that the request is filed with the Plan Administrator at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If a request for an extension of benefits is received within 24 hours of the expiration of the prescribed period of time or number of treatments, the request shall be treated as an Urgent Care Claim or a Pre-Service Claim, as applicable.

(iii) Upon the filing of a Health Claim that is a Pre-Service Claim, the Plan Administrator shall notify the Claimant within 15 days after receipt of a Pre-Service Claim if the Claimant failed to follow the procedures for filing a Pre-Service Claim and shall provide the proper procedures to be followed. The Plan Administrator shall notify the Claimant of its determination (whether adverse or not) by issuing, as applicable, a Notice of Denial or a notice of complete grant, within a reasonable period of time as appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan Administrator unless the Plan Administrator determines, in its discretion, that special circumstances require an extension of time for processing the claim. If an extension of time is required, a written or electronic extension notice indicating the special circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision shall be furnished to the Claimant prior to the expiration of the initial 15-day period. If the extension is necessary for reasons beyond the Plan Administrator's control, the extension shall not exceed a period of 15 days from the end of the initial 15-day period. If the

extension is necessary because of the failure of a Claimant to provide missing information and the Claimant is so notified of such fact, the extension shall not exceed a period of 15 days beginning as of the earlier of (i) the date the Claimant response is received by the Plan Administrator (without regard to whether all the missing information is provided) or (ii) the end of the period afforded to the Claimant to provide the missing information. The Claimant shall be afforded at least 45 days from the receipt of the notice within which to provide the missing information.

(iv) Upon the filing of a Health Claim that is a Post-Service Claim, the Plan Administrator shall notify the Claimant of an adverse benefit determination by issuing a Notice of Denial, within a reasonable period of time, but not later than 30 days after receipt of the claim by the Plan Administrator unless the Plan Administrator determines, in its discretion, that special circumstances require an extension of time for processing the claim. If an extension of time is required, a written or electronic extension notice indicating the special circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision shall be furnished to the Claimant prior to the expiration of the initial 30-day period. If the extension is necessary for reasons beyond the Plan Administrator's control, the extension shall not exceed a period of 15 days from the end of the initial 30-day period. If the extension is necessary because of the failure of a Claimant to provide missing information and the Claimant is so notified of such fact, the extension shall not exceed a period of 15 days beginning as of the earlier of (i) the date the Claimant response is received by the Plan Administrator (without regard to whether all the missing information is provided) or (ii) the end of the period afforded to the Claimant to provide the missing information. The Claimant shall be afforded at least 45 days from the receipt of the notice within which to provide the missing information.

(v) Upon the filing of claim other than a Health Claim, the Plan Administrator shall notify the Claimant of an adverse benefit determination by issuing a Notice of Denial, within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan Administrator unless the Plan Administrator determines, in its discretion, that special circumstances require an extension of time for processing the claim. If an extension of time is required, a written or electronic extension notice indicating the special circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision shall be furnished to the Claimant prior to the expiration of the initial 90-day period. In no event shall the extension exceed a period of 90 days from the end of the initial 90-day period.

(d) Upon a determination by the Plan Administrator (excluding a determination made as a result of an amendment to or the termination of the Plan) to reduce or terminate benefits approved under a previously filed Health Claim, the Plan Administrator shall provide the Claimant with a written or electronic Notice of Denial

sufficiently in advance to appeal the determination before the reduction or termination of benefits occur.

(e) A Claimant who wishes to appeal a Notice of Denial shall follow the procedures an appeal as set forth in Section 7.4.

7.4. Appeals Procedures. A Claimant who wishes to appeal a Notice of Denial shall follow the administrative procedures for an appeal as set forth in this Section and shall exhaust such administrative procedures prior to seeking any other form of relief. Appeals shall be reviewed in accordance with the procedures established by the Plan Administrator (or its delegate) subject to the following administrative procedures set forth in this Section.

(a) A Claimant must file an appeal of a Notice of Denial with the Plan Administrator within the following time periods:

(i) 60 days after receipt of a Notice of Denial with respect to any non-Health Claim.

(ii) 60 days after receipt of a Notice of Denial with respect to a Health Claim resulting from a determination by the Plan Administrator to reduce or terminate benefits approved under a previously filed Health Claim.

(iii) 180 days after receipt of a Notice of Denial with respect to any other Health Claim.

(b) The Claimant's appeal must be made in writing and may include written comments, documents, records, and other information relating to his or her claim. The Claimant may review all pertinent documents and, upon request, shall have reasonable access to or be provided free of charge, copies of all documents, records, and other information relevant to his or her claim. Notwithstanding the foregoing, in the case of Notice of Denial of an Urgent Care Claim, the Claimant may submit an appeal orally or in writing and all necessary information may be transmitted between the Plan Administrator and the Claimant by telephone, facsimile, or other available similarly expeditious method.

(c) The Plan Administrator shall provide a full and fair review of the appeal as follows:

(i) The Plan Administrator shall take into account all claim related comments, documents, records, and other information submitted by the Claimant without regard to whether such information was submitted or considered under the initial determination or review of the initial determination.

(ii) The Plan Administrator shall provide a review that does not afford deference to the initial determination or review of the initial determination. The review shall be conducted by an individual or committee of individuals who is

neither the individual or individuals who made the initial determination to issue the Notice of Denial or who reviewed the Notice of Denial nor a subordinate or subordinates of such individual or individuals.

(iii) The Plan Administrator shall review an appeal that is based in whole or in part on a medical judgment, including a determination as to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, in consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment (or any other professional the Plan Administrator considers appropriate in its discretion) and who was neither previously consulted in connection with the initial determination to issue the Notice of Denial or the review of the Notice of Denial nor is a subordinate of the health care professional previously consulted.

(iv) The Plan Administrator shall, upon request by the Claimant, identify the medical or vocational experts whose advice was obtained in connection with the initial determination to issue the Notice of Denial, the review of the Notice of Denial, or review of the appeal, without regard to whether the advice was relied upon in the determinations or reviews.

(d) The Plan Administrator shall notify a Claimant of its decision upon review of an appeal as follows:

(i) Upon the filing of an appeal of a Notice of Denial of a Health Claim that is an Urgent Care Claim, the Plan Administrator shall notify the Claimant of its determination (whether adverse or not) by issuing, as applicable, a Notice of Denial of Appeal or a notice of complete grant, as expeditiously as possible, but not later than 72 hours after receipt of the Claimant's request for an appeal by the Plan Administrator.

(ii) Upon the filing of an appeal of a Notice of Denial of a Health Claim that is a Pre-Service Claim, the Plan Administrator shall notify the Claimant of its determination (whether adverse or not) by issuing, as applicable, a Notice of Denial of Appeal or a notice of complete grant, within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the Claimant's request for an appeal by the Plan Administrator.

(iii) Upon the filing of an appeal of a Notice of Denial of a Health Claim that is a Post-Service Claim, the Plan Administrator shall notify the Claimant of its determination (whether adverse or not) by issuing, as applicable, a Notice of Denial of Appeal or a notice of complete grant, within a reasonable period of time appropriate to the medical circumstances, but not later than 60 days after receipt of the Claimant's request for an appeal by the Plan Administrator.

(iv) Upon the filing of an appeal of a Notice of Denial of a claim other than a Health Claim, the Plan Administrator shall notify the Claimant of its determination (whether adverse or not) by issuing, as applicable, a Notice of Denial of Appeal or a notice of complete grant, within a reasonable period of time but not later than 60 days after receipt of the Claimant's request for an appeal by the Plan Administrator. The Plan Administrator may extend the time to review the appeal if the Plan Administrator determines, in its discretion, that special circumstances require an extension of time. If an extension of time is required, a written or electronic extension notice indicating the special circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision shall be furnished to the Claimant prior to the expiration of the initial 60-day period following receipt of the Claimant's request for appeal. The extension shall not exceed a period of 60 days from the end of the initial 60-day period.

7.5. Voluntary Appeal for External Review. A Claimant who has been issued a Notice of Denial on Appeal may file a voluntary request for external review of a claim under the procedures established by the Plan Administrator (or its delegate) subject to the following administrative procedures set forth in this Section.

(a) Requests for external review under this Section shall be limited to claims that are both (i) denied on the basis that the care was not medically necessary or was experimental or investigational and (ii) the cost of such services or treatments for which the Claimant is responsible exceeds \$500.

(b) A Claimant must file, at his or her own cost, a request for external review with the Plan Administrator within 60 days after receipt of the Notice of Denial on Appeal by completing a *Request for External Review Form* which must be accompanied by the Notice of Denial on Appeal and all other pertinent information that supports the claim.

(c) An external review shall be conducted by an independent physician, with appropriate expertise in the area at issue, of claim denials and denials based upon lack of medical necessity, or the experimental or investigational nature of a proposed service or treatment. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by the Claimant and shall follow the provisions of the Plan.

(d) The Plan Administrator shall notify the Claimant of the external reviewer's determination generally within 30 days of the Plan Administrator's receipt of the request for external review. If the Claimant's physician certifies (by telephone or on a separate *Request for External Review Form*) that a delay in receiving the service would jeopardize the Claimant's health, the Plan Administrator shall notify the Claimant of the external reviewer's determination within 3-5 calendar days of the Plan Administrator's receipt of the request for external review.

(e) Any applicable statute of limitations shall be tolled while the Claimant's request for external review is pending.

If a Claimant chooses not to file a request for external review pursuant to this Section, he or she may seek any other form of relief and shall not be treated as having failed to exhaust the Plan's claims and appeals procedures.

7.6. Review Procedures for Eligibility Determination. If an Employee has not filed a claim for benefits and has not been issued a Notice of Denial pursuant to Section 7.3 and believes that he or she is being denied enrollment in the Plan or if a Participant's enrollment (or the enrollment of a Covered Dependent) has been terminated for cause pursuant to Section 3.10 and believes that his or her enrollment in the Plan should not be terminated, then such Employee shall follow the administrative procedures for the filing an appeal of a Notice of Denial of a claim other than a Health Claim as set forth in Section 7.4. All appeals as described herein shall be reviewed in accordance with the procedures established by the Plan Administrator subject to the administrative procedures for the filing of a claim other than a Health Claim as set forth in Section 7.4.

7.7. Definitions. For purposes of this Article VII, the following definitions shall apply:

(a) "Authorized Representative" shall mean any person or entity designated as such by a Claimant in accordance with reasonable procedures established by the Plan Administrator; provided, however, in the case of an Urgent Care Claim where the Claimant is unable to act on his or her behalf, any health care professional or Physician with knowledge of the Claimant's medical condition can act as the Claimant's duly Authorized Representative without regard to such procedures.

(b) "Claimant" shall mean any Participant or any Covered Dependent (or his or her Authorized Representative) who files an Urgent Care Claim or Pre-Service Claim or any Participant or any Covered Dependent (or his or her Authorized Representative) who, after the initial processing of benefit payments, files a Post-Service Claim or any other claim other than a Health Claim. The term "Claimant" shall also include any individual who after initiating and filing a claim for benefits is denied benefits because the individual is determined not to be eligible for coverage under the Plan.

(c) "Health Claim" shall mean a claim for benefits under the Plan that provides medical care within the meaning of Section 733 of ERISA.

(d) "Notice of Denial" shall mean a written or electronic notice that is issued by the Plan Administrator to a Claimant following an adverse benefit determination which includes any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of the Claimant's eligibility to participate in the Plan, and including, with respect to Health Claim, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part)

for, a benefit resulting from a determination of a Claims Administrator, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. A Notice of Denial shall set forth, in a manner calculated to be understood by the Claimant, the following: (i) the specific reason or reasons for the adverse determination; (ii) the specific reference to pertinent provisions of the Plan upon which the benefit determination is based; (iii) a description of any missing or additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary; and (iv) an explanation of the Plan's appeals procedures (or the Plan's expedited appeals procedures in the case of an Urgent Care Claim) and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following a Notice of Denial on Appeal. In the case of a Health Claim, the Notice of Denial shall also to the extent applicable (i) set forth the internal rule, guideline, protocol or other similar criterion upon which the Notice of Denial was based or indicate that such was relied upon and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge upon request and (ii) explain the scientific or clinical judgment (by applying the terms of the Plan to the Claimant's medical circumstances) used to determine a medical necessity or experimental treatment or similar exclusion or limit upon which the Notice of Denial was based or indicate that such was relied upon and that an explanation will be provided free of charge upon request. In the case of Notice of Denial of an Urgent Care Claim, the information described in this subsection may be provided to the Claimant orally within the applicable time frames set forth in Section 7.3 above; provided, that a written or electronic Notice of Denial is furnished to the Claimant not later than 3 days after the oral notification.

(e) "Notice of Denial on Appeal" shall mean a written or electronic decision that is issued by the Plan Administrator following an adverse benefit determination (as defined in subsection (d) above) upon appeal. A Notice of Denial on Appeal shall set forth, in a manner calculated to be understood by the Claimant, the following: (i) the specific reason or reasons for the adverse determination on appeal; (ii) the specific reference to pertinent provisions of the Plan upon which the benefit determination is based; (iii) a statement that the Claimant is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records and other information relevant to the Claimant's claim for benefits; (iv) a statement describing the Plan's procedures for voluntary appeals for external review and the Claimant's right to obtain information about such procedures; and (v) a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA. In the case of a Health Claim, the Notice of Denial on Appeal shall also to the extent applicable: (i) set forth the internal rule, guideline, protocol or other similar criterion upon which the Notice of Denial on Appeal was based or indicate that such was relied upon and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge upon request and (ii) explain the scientific or clinical judgment (by applying the terms of the Plan to the Claimant's medical circumstances) used to determine a medical necessity or experimental treatment or similar exclusion or limit upon which the Notice of Denial on Appeal was based or

indicate that such was relied upon and that an explanation will be provided free of charge upon request.

(f) “Post-Service Claim” shall mean a Health Claim with respect to which (i) advance approval is not a prerequisite to the receipt of benefits, in whole or in part, or (ii) payment is being requested for medical care already rendered to the Claimant. The determination of whether a Health Claim is a Post-Service Claim shall be made in accordance with ERISA Regulations Section 2560.503-1(m)(3).

(g) “Pre-Service Claim” shall mean a Health Claim with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. The determination of whether a Health Claim is a Pre-Service Claim shall be made in accordance with ERISA Regulations Section 2560.503-1(m)(2).

(h) “Urgent Care Claim” shall mean a Health Claim with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or, 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 Health Claim. The determination of whether a Health Claim is an Urgent Care Claim shall be made in accordance with ERISA Regulations Section 2560.503-1(m)(1) and shall be judged at the time the claim or appeal is being processed.

ARTICLE VIII  
PLAN ADMINISTRATION

8.1. Plan Administrator. The Plan Administrator shall be the University or such other person or committee that may be so appointed from time to time by the University to administer the Plan. The University shall be the administrator within the meaning of Section 3(16)(A) of ERISA and the named fiduciary within the meaning of Section 402(a) of ERISA. For purposes of inspection by Employees, Participants and other eligible parties, the Plan Administrator shall maintain at the office of the Plan Administrator or other appropriate location a copy of the Plan, a copy of any other governing documents and an accurate schedule of the individual(s) who from time to time may serve as the named fiduciaries of the Plan.

8.2. Powers of the Plan Administrator. Authority to administer the Plan and to control and manage the operation of the Plan is vested in the Plan Administrator and the Plan Administrator shall have all the powers and authority necessary to supervise the administration and control the operation of the Plan. In addition to any powers and authority expressly conferred upon the Plan Administrator elsewhere in the Plan, the Plan Administrator shall have, by way of illustration and not by way of limitation, the following discretionary and final authority:

- (a) To construe and interpret the provisions of the Plan, including any uncertain terms;
- (b) To decide all questions of eligibility and participation under the Plan;
- (c) To establish such rules and procedures from time to time for the efficient administration and effectuation of the Plan;
- (d) To determine any disputes arising under and all questions concerning administration of the Plan;
- (e) To prepare and distribute information explaining the Plan in such manner as the Plan Administrator determines to be appropriate and as shall be required by law;
- (f) To request and receive from all Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of the Plan, subject to such limitations as shall be imposed by applicable law;
- (g) To furnish each Participant with such reports with respect to the administration of the Plan as the Plan Administrator determines to be reasonable and appropriate and as shall be required by law;
- (h) To appoint or employ such individuals or entities to assist in administration of the Plan as it determines to be necessary or advisable, including any Claims Administrator, legal counsel and benefit consultants;

(i) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan including the allocation and delegation of the responsibility to administer all or a part of the claims and appeals procedures applicable to a Claims Administrator;

(j) To establish utilization limitations as may be required under the Plan; and

(k) To perform any and all other acts necessary or appropriate for the proper management and administration of the Plan.

Any action taken or any determination made in good faith by the Plan Administrator in the exercise of authority conferred upon it by the Plan shall be conclusive and binding upon Employees, Participants and their beneficiaries and dependents. To the extent permitted under applicable law, any determination made by the Plan Administrator shall be given deference, if it is subject to judicial review, and shall be overturned only if it is arbitrary or capricious. All discretionary powers conferred upon the Plan Administrator shall be absolute, provided, however, all such discretionary power shall be exercised in a uniform and nondiscriminatory manner.

8.3. Reliance Upon Documents and Opinions. The Plan Administrator shall be entitled to rely upon (i) any tables, valuations, computations, estimates, certificates and reports furnished by a Claims Administrator or any consultant, or firm or corporation which employs one or more consultants, and (ii) any opinions furnished by legal counsel. The Plan Administrator shall be fully protected and shall not be liable in any manner whatsoever for anything done or action taken or suffered in reliance upon any such information, opinions or reports. Any and all things done or actions taken or suffered by the Plan Administrator shall be conclusive and binding on all Employees, Participants, and any other persons whomsoever except as otherwise provided by law. The Plan Administrator and a Claims Administrator may, but are not required to, rely upon all records of the University with respect to any matter or thing whatsoever, and may likewise treat those records as conclusive with respect to all Employees, Participants, and any other persons whomsoever except as otherwise provided by law.

8.4. Requirement of Proof; Independent Medical Examination. The Plan Administrator may require satisfactory proof of any matter under the Plan from or with respect to any Participant or Covered Dependent, and no person shall be entitled to receive benefits under the Plan until that proof shall be furnished. The Plan at its own expense shall have the right and opportunity to require the examination of the person whose injury or illness is the basis of a claim when and as often as may be reasonably required during the pendency of a claim. By accepting the benefits of the Plan, each Participant or Covered Dependent is deemed to consent to the Plan Administrator's right of access to his or her medical records to the extent permitted by applicable law.

8.5. Incapacity. If the Plan Administrator determines, or if so authorized by the Plan Administrator, the Claims Administrator, that a Participant by or for whom a claim has been made is incapable of furnishing a valid receipt of payment and in the absence of written evidence

to the Plan of the qualification of a guardian or personal representative for his or her estate, then the Plan Administrator or if so authorized by the Plan Administrator, the Claims Administrator, may in its sole discretion, make any and all such payments to the provider of medical services or other person providing for the care and support of such individual.

8.6. Recovery. Whenever payments have been made by the Plan Administrator, at any time, for covered expenses in a total amount in excess of the maximum amount of payment necessary at that time to satisfy the intent of the above provisions, the Plan Administrator shall have the right to recover these payments, to the extent of the excess, from the individual to whom, or for whom, or with respect to whom these payments have been made.

8.7. Records. The Plan Administrator shall cause to be kept all books, accounts, records or other data as may be necessary or advisable in its judgment for the administration of the Plan and properly to reflect the affairs thereof. Nothing in this Section shall require the Plan Administrator or any member thereof to perform any act, which, pursuant to law or the provisions of the Plan, is the responsibility of the University, nor shall this Section relieve the University from such responsibility.

8.8. Reporting and Disclosure. The University shall be responsible for the reporting and disclosure of information required to be reported or disclosed pursuant to ERISA or any other applicable law.

8.9. Indemnification. To the extent permitted by law, the University shall indemnify each Employee with duties under the Plan, against expenses (including any amount paid in settlement of claims) reasonably incurred by him or her in connection with any claims against him or her by reason of his or her conduct in the performance of his or her duties under the Plan, except in relation to matters resulting from willful misconduct, breach of good faith, or gross negligence in the performance of those duties. The preceding right of indemnification shall be in addition to any other right to which any such Employee may be entitled as a matter of law or otherwise.

8.10. Limitation on Liability. Except as provided in Part 4 of Title I of ERISA, no person shall be subject to any liability with respect to his or her duties under the Plan unless he or she acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated, except as provided in Part 4 of Title I of ERISA. No action or responsibility shall be deemed to be a fiduciary action or responsibility except to the extent required by ERISA.

8.11. Use and Disclosure of Health Information. Notwithstanding anything in the Plan to the contrary, this Section shall apply to the use and disclosure of Summary Health Information and Protected Health Information (see definitions in subsection (e) below for capitalized terms used in this Section):

- (a) The Plan may disclose Summary Health Information to the University if the University requests such information for the purpose of (i) obtaining premium bids

for health insurance coverage under the Plan or (ii) modifying, amending, or terminating the Plan. The Plan may disclose information to the University as to whether an individual is participating in the Plan or is enrolled in or has disenrolled from the Plan.

(b) The Plan may disclose Protected Health Information to the University to carry out Plan administration functions that the University performs, provided that the certification described in subsection (c) below is received, and for such other limited purposes provided for in such certification. Protected Health Information may also be used or disclosed with the consent or authorization of the individual. Except as otherwise required by law, when using, disclosing, or requesting the disclosure of Protected Health Information, the Plan shall make reasonable efforts to limit (i) the scope of the Protected Health Information and (ii) the number of recipients of such information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. The Plan shall not disclose Protected Health Information to the University for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the University.

(c) The Plan may disclose Protected Health Information to the University only upon receipt of the University's certification that (i) it agrees to comply with the provisions enumerated below and (ii) the Plan has been amended to incorporate such provisions.

(i) The University shall not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(ii) The University shall ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the University with respect to such information;

(iii) The University shall not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the University;

(iv) The University shall report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(v) The University shall provide each individual with access to his or her Protected Health Information as required by law;

(vi) The University shall give each individual the right to have the University (or other covered entity) amend the individual's Protected Health Information or record as required by law;

(vii) The University shall provide each individual with the right to receive an accounting of disclosures of Protected Health Information as required by law;

(viii) The University shall make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Labor for purposes of determining compliance by the Plan with applicable law;

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

(x) The University shall ensure that the adequate protections described in subsection (d) below is established.

(d) Protected Health Information shall be disclosed only to those employees of the University who are employed in the human resources division of the University and who are responsible for administering the Plan or who have oversight responsibility for any third-party claims administrator for the Plan. If such employees perform functions for the University other than Plan administrative or oversight duties, then such employees shall not use any Protected Health Information for any purpose other than Plan administration or oversight. Any individual who believes that the Protected Health Information provisions of this Section have been breached may file a complaint with the Privacy Official in accordance with separate written complaint procedures that are available upon request.

(e) For purposes of this Section, the following definitions shall apply:

(i) “Individually Identifiable Health Information” shall mean health information, whether oral or recorded in any form or medium, including demographic information collected from an individual, that (i) is created or received by a health care provider, health plan, public health authority, life insurer, school or university, health care clearinghouse, or employer, (ii) either (1) relates to the past, present, or future physical or mental health or condition of an individual, (2) the provision of health care to an individual, or (3) the past, present, or future payment for the provision of health care to an individual, and (iii) either identifies the individual or there is a reasonable basis to believe such information can be used to identify the individual.

(ii) “Privacy Official” shall mean the individual designated by the University on behalf of the Plan who is responsible for the implementation of the Plan’s privacy policies and procedures.

(iii) “Protected Health Information” shall mean Individually Identifiable Health Information, whether such information is transmitted or maintained electronically or otherwise, including oral communications.

(iv) “Summary Health Information” shall mean information, which may be Individually Identifiable Health Information, that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom an employer has provided health benefits under a group health plan, but excludes the following identifiers: the name of the individual and all dates directly related to the individual (such as birth date, admission date, discharge date, date of death); the individual’s telephone number, fax number, electronic mail address, social security number, medical record numbers, account numbers, license plate numbers; all geographic subdivisions smaller than a State, except the first three digits of a zip code may be used if the geographic unit formed by combining all zip codes within the same three digits contains more than 20,000 people; and other information set forth in 45 CFR § 164.514(b)(2)(i).

ARTICLE IX  
AMENDMENT OR TERMINATION OF PLAN

9.1. Amendment of Plan. The University reserves the right at any time or times and for any or no reason to amend, or modify, to any extent the provisions of the Plan. For purposes of this Section, amendments and modifications to the Plan established hereunder may be made as follows:

(a) By action of the University's Board of Trustees or duly appointed committee.

(b) By action of the Associate Vice President of Human Resources or the Vice President of Finance and Administration with respect to technical and legal amendments to comply with federal tax and labor laws as amended from time to time. This subsection shall be effective as of the date authorization is granted to such officers by the University's Board of Trustees.

(c) By action of the Associate Vice President of Human Resources or the Vice President of Finance and Administration with respect to changes to the "coverage and benefits provisions" of the Plan to the extent such changes result in little or no increased costs to the University. For this purpose, the term "coverage and benefits provisions" shall mean any provision of the Plan that entitle Employees to participate in the Plan or to receive any payments or benefits under the Plan. A change in the coverage and benefits provisions may be effected by publication and distribution by the University of authorized written materials designed to communicate the changes, describing the revised coverage and benefits provisions. These written materials shall be attached hereto and made a part of the Plan and their provisions shall be incorporated in the Plan by this reference. This subsection shall be effective as of the date authorization is granted to such officers by the University's Board of Trustees.

9.2. Termination of Plan. The University has established the Plan established hereunder with the bona fide intention and expectation that it shall continue indefinitely, but the University shall have no obligation whatsoever to maintain the Plan established hereunder for any given length of time. The University may discontinue or terminate the Plan, by action of its Board of Trustees or duly appointed committee, at any time without liability. In the event of termination or discontinuance, the University will notify all Participants of the termination or discontinuance.

ARTICLE XII  
MISCELLANEOUS

10.1. No Enlargement of Employee Rights. The Plan is strictly a voluntary undertaking on the part of the University and shall not be deemed to constitute a contract between the University and any Employee, or to be consideration for, or an inducement to, or a condition of, the employment of any Employee. Nothing contained in the Plan shall be deemed to give any Employee the right to be retained in the employ of the University or to interfere with the right of the University to discharge or retire any Employee at any time.

10.2. Funding of Plan. The Plan established hereunder is unfunded and any Participant Contributions shall not be placed in trust but shall be considered a part of the general assets of the University. Nothing in the Plan shall be construed to require the University to establish a trust or maintain any fund or segregate any amount for the benefit of any Participant unless otherwise required by law.

10.3. No Guarantee of Tax Consequences. Neither the University nor the Plan Administrator makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan shall be excludable from the Participant's gross income for federal or state tax purposes, or that any other federal or state tax treatment shall apply to or be available to any Participant. It shall be the obligation of each Participant to notify the University if such Participant has reason to believe that any the payment is not so excludable.

10.4. Nonassignability of Rights. Except for assignments of the right of reimbursement to benefit providers, benefits payable under the Plan shall not be alienable by a Participant by assignment or any other method (except with the consent of the University or as otherwise specifically provided in the Plan), and shall not be subject to claims of a Participant's creditors by any process whatsoever. Any attempt to subject a Participant's right of reimbursement to creditor claims shall not be recognized except to the extent as may be required by law.

10.5. Interpretation. Article and Section headings are for convenient reference only and shall not be deemed to be part of the substance of this instrument or in any way to enlarge or limit the contents of any Article or Section. The provisions of the Program shall in all cases be interpreted in a manner that is consistent with (i) the Program qualifying as an "accident and health plan" within the meaning of Section 105(e) of the Code and (ii) the exclusion from gross income of payments or reimbursements made hereunder in accordance with Code Section 105(b).

10.6. Governing State Law. The Plan shall be construed and enforced according to the laws of the State of Texas to the extent not preempted by federal law.

10.7. Successors and Assigns. The Plan shall inure to the benefit of, and be binding upon, the parties hereto and their successors and assigns.