

**YALE UNIVERSITY  
WELFARE AND FRINGE BENEFIT PLAN**

**(AMENDED AND RESTATED EFFECTIVE AS OF JANUARY 1, 2019)**

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Exhibit A – Component Plans

**YALE UNIVERSITY WELFARE AND FRINGE BENEFIT PLAN  
(AMENDED AND RESTATED EFFECTIVE AS OF JANUARY 1, 2019)**

**Introduction**

Yale University (the “University”) sponsors the Yale University Welfare and Fringe Benefit Plan (the “Plan”) (plan number 525), which consists of various employee welfare benefit programs established for the exclusive benefit of its Eligible Employees and their Dependents (each a “Component Plan”).

This is an amendment and restatement of the Plan effective as of January 1, 2019, which is intended to reflect changes in Plan design and applicable law since the Plan was last restated and to otherwise meet current needs. The University hereby amends and restates the Plan effective as of January 1, 2019, which shall supersede any and all prior Plan documents, including the Yale University Welfare and Fringe Benefits Plan, as amended and restated effective as of January 1, 2002 (the “2002 Restatement”), and any amendments thereto.

The Plan is intended to comply with all relevant provisions of the Code and ERISA and must be interpreted in a manner consistent with the requirements of such laws. The Plan consists of this document and the Incorporated Documents, but is, and must be treated as, a single welfare benefit plan solely for purposes of annual Form 5500 filings. For all other purposes under ERISA, the Code, COBRA, HIPAA, ACA and any other applicable legal requirements, each Component Plan is, and must be treated as, a separate plan. Benefits under the Yale Dental Program, the Yale Vision Program and the Yale Health Care Reimbursement Account Program are “excepted benefits” as defined in Section 732(c) of ERISA and Sections 9831(c)(1) and 9832(c)(2) of the Code.

## **ARTICLE I DEFINITIONS**

The following terms when used in the Plan have the following meanings, unless otherwise defined in the applicable Component Plan or a different meaning is plainly required by the context. Words with initial capital letters not defined herein have the meanings ascribed to them in the applicable Component Plan.

### **1.1 ACA**

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended. References to ACA include the valid and binding governmental regulations, court decisions and other regulatory and judicial authority issued or rendered thereunder

### **1.2 Beneficiary**

The individual or entity designated by a Participant or otherwise entitled pursuant to any Component Plan, as applicable, to receive benefits under the Component Plan attributable to the Participant after, or on account of, the Participant's death. Unless otherwise provided in the applicable Component Plan, a Beneficiary designation, including a change in Beneficiary designation, is not effective unless made in the form and in accordance with the procedure prescribed for Beneficiary designations and properly filed.

### **1.3 Child**

Except as may otherwise be provided in a Component Plan, for purposes of each separate Component Plan that covers eligible Dependent Children, a person who is the Participant's or Participant's Spouse's or Grandfathered Domestic Partner's:

- (a) natural child;
- (b) stepchild;
- (c) legally adopted child (including a child placed in the Participant's or Participant's Spouse's or Grandfathered Domestic Partner's home for the purpose of legal adoption by the Participant or Participant's Spouse or Grandfathered Domestic Partner as long as the child remains in the Participant's or Participant's Spouse's or Grandfathered Domestic Partner's home and the adoption procedure has not been terminated, and whether or not the adoption has become final);
- (d) foster child; and
- (e) child for whom the Participant and/or the Participant's Spouse or Grandfathered Domestic Partner are the legal guardian.

Subject to any additional requirements set forth in the applicable Component Plan, a person ceases to be a Child of a Participant on the first day on which the person no longer meets the requirements to be a Child as described in this Section.

**1.4 Claimant**

An individual who makes an eligibility or enrollment claim or a claim for benefits under a Component Plan.

**1.5 Claims Administrator**

An individual, committee, third party administrator or Insurer designated by the University or its delegate to review and process claims for benefits under a Component Plan.

**1.6 COBRA**

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. References to COBRA include the valid and binding governmental regulations, court decisions and other regulatory and judicial authority issued or rendered thereunder.

**1.7 COBRA Continuation Coverage**

Continuation of coverage elected under COBRA.

**1.8 Code**

The Internal Revenue Code of 1986, as amended. References to the Code include the valid and binding governmental regulations, court decisions and other regulatory and judicial authority issued or rendered thereunder.

**1.9 Component Plans**

The specific arrangements by which the Plan provides certain types of benefits. A Component Plan may be changed from time to time as specified in such Component Plan or by the Plan Administrator. The Component Plans are listed on Exhibit A.

**1.10 Dependent**

Subject to any additional requirements set forth in the applicable Component Plan, or as set forth in this Section, a Participant's (or deceased Participant's):

- (a) Spouse;
- (b) Grandfathered Domestic Partner; or
- (c) Child who is:
  - (1) less than age 26; or

- (2) any age if the Child is unmarried and primarily supported by the Participant and incapable of self-sustaining employment by reason of mental or physical disability which arose while the Child was covered as a Dependent under the Plan.

In addition to the requirements of Subsections (a) through (c) of this Section, the term “Dependent” for purposes of the Component Plans is limited to a person who is the Participant’s dependent for purposes of Section 213(d) or 105(b) of the Code, as applicable, or, with respect to eligibility for health coverage under the Component Plans (except for eligibility for coverage of a Grandfathered Domestic Partner or a Grandfathered Domestic Partner’s Child), meets the Code requirements for such coverage, and resulting benefits, to be received tax-free under Sections 104, 105 and 106 of the Code, including references to a dependent under Section 152 of the Code.

### 1.11 Eligible Employee

- (a) **General:** An Employee of the Employer who is eligible to participate in and receive benefits under one or more of the Component Plans. An Employee’s eligibility to receive benefits under the Plan is dictated by and limited to the Employee’s eligibility to receive benefits under the applicable Component Plan. The eligibility rules for each Component Plan are set forth in the applicable Incorporated Documents. Notwithstanding anything in an Incorporated Document to the contrary, an Employee is an Eligible Employee if the Employee is not otherwise eligible to participate in the Plan or any Component Plan but is considered a “full-time employee” as defined under ACA and as determined by the Employer in its sole discretion, in accordance with policies and procedures established by the Employer in compliance with applicable legal requirements.
- (b) **Exclusions:** Notwithstanding anything in this Section to the contrary, an Eligible Employee does not include:
  - (1) Any individual who performs services for the University and who is classified or paid as an independent contractor as determined by the personnel and payroll records of the University for the period during which the individual is so classified or so holds himself out, whether or not any such individual is subsequently determined by the Internal Revenue Service or others to be a common-law employee of the Employer;
  - (2) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not the individual is subsequently determined by the Internal Revenue Service or others to be a common law employee of the Employer;



- (3) any Employee whose terms and conditions of employment are subject to collective bargaining, unless there is in effect a collective bargaining agreement that expressly provides for participation in the Plan;
- (4) any non-resident alien who has no U.S. source of income or any individual who is not on the U.S. payroll of the Employer;
- (5) any Employee who is not eligible for coverage or participation under any of the Component Plans;
- (6) any Employee whose terms and conditions of employment with the Employer expressly preclude such Employee's participation in the Plan;
- (7) any Employee who is employed by a division or other business unit or operation of the Employer to which division, unit or operation the Plan has not been extended; and
- (8) any Employee who is classified as a student enrolled as an undergraduate, graduate, or professional student and who is also not classified as a benefit-eligible Employee as determined by the payroll or personnel records maintained by the University.

#### **1.12 Employee**

Any person employed by the Employer who is classified as an employee by the Employer for U.S. federal income tax withholding purposes (whether or not such classification is ultimately determined to be correct as a matter of law) and/or for whom the Employer makes contributions to Social Security.

#### **1.13 Employer**

The University.

#### **1.14 ERISA**

The Employee Retirement Income Security Act of 1974, as amended. References to ERISA include the valid and binding governmental regulations, court decisions and other regulatory and judicial authority issued or rendered thereunder.

#### **1.15 FMLA**

The Family and Medical Leave Act of 1993, as amended. References to the FMLA include the valid and binding governmental regulations, court decisions and other regulatory and judicial authority issued or rendered thereunder.

### **1.16 Grandfathered Domestic Partner**

An Employee's domestic partner that was enrolled in a Component Plan prior to April 1, 2006 and has continually met the requirements for domestic partnership since April 1, 2006.

### **1.17 HIPAA**

The Health Insurance Portability and Accountability Act of 1996, as amended. References to HIPAA include the valid and binding governmental regulations, court decisions and other regulatory and judicial authority issued or rendered thereunder.

### **1.18 Incorporated Documents**

The plan documents/summary plan descriptions, Insurance Contracts or other documents under which health and welfare benefits are provided to Eligible Employees and/or Dependents and which are described in Exhibit A, including any and all attachments, amendments and supplements thereto, as well as any documents incorporated by reference into such plan documents/summary plan descriptions, Insurance Contracts or other documents, including, without limitation, applications and certificate of insurance booklets.

### **1.19 Insurance Company or Insurer**

An insurance company that enters into an Insurance Contract with the University to provide benefits coverage or benefits under one or more of the Component Plans.

### **1.20 Insurance Contract**

Each insurance policy, contract and/or other agreement issued by, or entered into with, an Insurance Company pursuant to which the Insurance Company accepts the risk and obligation to provide benefits coverage or benefits under any of the Component Plans, and all amendments and endorsements thereto.

### **1.21 Medical Plan**

The Yale University Medical Program.

### **1.22 Named Fiduciary**

An individual or entity designated in Article V to carry out fiduciary responsibilities under any of the Component Plans as set forth in the Plan.

### **1.23 Participant**

An Eligible Employee who is properly enrolled as such in a Component Plan and is paying any required contributions.

#### **1.24 Plan**

The Yale University Welfare and Fringe Benefit Plan as set forth herein, together with any and all amendments and supplements hereto.

#### **1.25 Plan Administrator**

The University.

#### **1.26 Plan Year**

Except as a Component Plan may otherwise provide, the plan year for each of the Component Plans is the 12-month period beginning each January 1 and ending the following December 31; provided, however, that if there is a valid business purpose, a period of less than 12 months may be a Plan Year for the final Plan Year or a transition period to a different Plan Year.

#### **1.27 Spouse**

A person to whom the Participant is legally married in any domestic or foreign jurisdiction, regardless of the person's or the Participant's state of residence, which such legal marriage may include "common-law marriage." A person claiming to be a Spouse may be required to establish to the satisfaction of the Plan Administrator, with such documentation, certifications and affidavits as may be required by the Plan Administrator, that a marriage exists under applicable law. The Plan Administrator may notify other Beneficiaries, contingent or otherwise, in the event of a claim by a purported spouse and may take such action as it deems appropriate, including the filing of interpleader or declaratory judgment actions if conflicting claims or the potential therefore exist. Subject to any additional requirements, or survivor coverage provisions set forth in the applicable Component Plan, a person ceases to be the Spouse of a Participant as of the date their marriage is legally terminated by divorce or annulment. Prior to a final date of divorce or annulment, "Spouse" includes an individual legally separated from the Participant under a valid separation agreement or separate maintenance decree, unless such agreement or decree explicitly specifies that the Participant does not have to provide benefits coverage for such individual any longer, in which case such individual ceases to be a "Spouse" under the terms of the Plan or any Component Plan as of the date of such agreement or decree. Notwithstanding anything in this Section to the contrary, a Spouse does not include any person in another formal relationship with the Participant, such as a marriage-equivalent civil union or registered domestic partnership, unless and until such person legally marries the Participant and becomes the Participant's Spouse as described in the first sentence of this Section.

#### **1.28 University**

Yale University.

**1.29 USERRA**

The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended. References to USERRA include the valid and binding governmental regulations, court decisions and other regulatory and judicial authority issued or rendered thereunder.

**1.30 Yale Corporation**

The governing board of the University, or a duly appointed committee thereof, as each may from time to time be constituted.

## ARTICLE II PARTICIPATION

### 2.1 Commencement of Participation

Subject to any additional limitations set forth in the applicable Component Plan, each Eligible Employee becomes a Participant on the date such Eligible Employee becomes a participant in a Component Plan in accordance with the terms of the Component Plan.

### 2.2 Cessation of Participant's Participation

- (a) **Effective Date of Termination:** A Participant's participation and coverage (and that of the Participant's eligible Dependents) cease as of the earliest of:
- (1) the date on which the Plan is terminated;
  - (2) the date on which the Participant ceases to be an Eligible Employee under each Component Plan in which such Participant is eligible to participate, and the Participant's benefit coverage expires as set forth in such Component Plans;
  - (3) the end of the period for which the Participant made the last required contribution under all Component Plans; and
  - (4) the effective date of the Participant's cancellation of coverage under each Component Plan in which such Participant is eligible to participate.
- (b) **Availability of Continued Coverage:** Notwithstanding any other provision of this Section to the contrary, an Eligible Employee Participant who is absent by reason of sickness, disability or other authorized leave of absence may continue as a Participant during such authorized absence in accordance with, and subject to, the Plan Administrator's rules and regulations. In addition, qualified beneficiaries as defined under COBRA are entitled to enroll in COBRA Continuation Coverage under certain Component Plans as described in Section 2.4.
- (c) **No Rescissions:** Notwithstanding any other provision of this Section to the contrary, the cessation of a Participant's participation and coverage (and that of the Participant's eligible Dependents) under the Medical Plan will comply with the requirements of Section 2712 of the Public Health Service Act (regarding restrictions on rescissions), as incorporated by reference into Section 715 of ERISA and Section 9815 of the Code (including the valid and binding governmental regulations, court decisions and other regulatory and judicial authority issued or rendered thereunder), in accordance with rules and procedures established by the Plan Administrator or its delegate.

## 2.3 Cessation of Dependent's Participation

- (a) **Effective Date of Termination:** An eligible covered Dependent's participation and coverage cease as of the earliest of:
- (1) the date on which the Participant's coverage under the Plan ends;
  - (2) the last day of the month during which such Dependent ceases to be an eligible Dependent under each Component Plan in which such Dependent is eligible to participate and the Dependent's benefit coverage expires as set forth in such Component Plans;
  - (3) the end of the period for which the Participant made the last required contribution for the Dependent's coverage under all Component Plans; and
  - (4) the effective date of the Participant's cancellation of coverage for the Dependent under each Component Plan in which such Dependent is eligible to participate.
- (b) **No Rescissions:** Notwithstanding any other provision of this Section to the contrary, the cessation of a covered Dependent's participation and coverage under the Medical Plan will comply with the requirements of Section 2712 of the Public Health Service Act (regarding restrictions on rescissions), as incorporated by reference into Section 715 of ERISA and Section 9815 of the Code (including the valid and binding governmental regulations, court decisions and other regulatory and judicial authority issued or rendered thereunder), in accordance with rules and procedures established by the Plan Administrator or its delegate.

## 2.4 COBRA Continuation Coverage

If, as a result of the occurrence of any "qualifying event" as defined in Section 4980B(f)(3) of the Code, an Eligible Employee (and/or any of such Employee's covered Dependent(s)) loses coverage under a Component Plan that is a "group health plan" under Section 4980B of the Code and Section 601 of ERISA, such affected Eligible Employee (and/or Dependent(s)) will be given the option of electing COBRA Continuation Coverage.

## 2.5 Reinstatement of Former Participants

A former Participant who is reemployed by the Employer as an Eligible Employee again becomes a Participant after meeting the requirements of Section 2.1.

## 2.6 Participation During Leaves of Absence under the FMLA

Notwithstanding any other provision of the Plan to the contrary, an Eligible Employee Participant who is on an authorized leave of absence under the FMLA may continue participation in the Plan for up to 12 weeks (or up to 26 weeks in the case of military

caregiver leave under the FMLA). Such participation is provided under the terms and conditions of the Plan and the Component Plans (including rate of contributions) that would have been provided if the Participant had continued employment and is subject to the terms and conditions of the Employer's policies regarding paid and unpaid leaves of absence under the FMLA.

## **2.7 Participation During Periods of Qualified Military Service under USERRA**

The Plan Administrator ensures that the Plan fully complies with the provisions of USERRA at all times.

**ARTICLE III  
BENEFITS AVAILABLE**

**3.1 Description of Benefits**

The benefits available under the Plan consist of the aggregate of the benefits available under each Component Plan, including all limitations and exclusions with respect to each Component Plan's benefits. Exhibit A contains a brief description of the benefits provided by each Component Plan. The availability of benefits under any Component Plan is subject to payment by the Participant of all applicable contributions thereunder, if any. The availability of benefits under certain Component Plans is subject to proper enrollment by the Participant in such Component Plans.

**3.2 Incorporated Documents**

The Plan incorporates by reference the Incorporated Documents, which contain the substantive provisions governing benefits provided through the Plan. As the Incorporated Documents are amended or superseded, the amended or successor documents automatically become Incorporated Documents. Except as otherwise provided in this Section, in the event of any conflict between the provisions of the Plan and an Incorporated Document, the provisions of the Incorporated Document govern. If there is no provision in an Incorporated Document corresponding to a provision of the Plan, to the extent applicable, the Plan provisions apply to the Incorporated Document. If a provision in an Incorporated Document is legally insufficient, the applicable provisions of the Plan apply to the Incorporated Document to the extent deemed necessary by the Plan Administrator. In any event, Article V and Article VII override the corresponding provisions of any Incorporated Document.



## **ARTICLE IV FUNDING OF BENEFITS**

### **4.1 Funding of Benefits**

Funding for the Plan consists of the combined funding for all Component Plans. The University has the right, in its sole discretion, to (a) pay benefits from its general assets, (b) insure any benefits under the Plan and/or (c) establish any fund or trust for the holding of contributions or payment of benefits under the Plan, either as mandated by law or as the University deems advisable. In addition, the University has the right to alter, modify or terminate any method used to fund the payment of benefits under the Plan, including, but not limited to, any trust or Insurance Contract.

### **4.2 Self-Insured Benefits Solely from General Assets**

To the extent certain benefits or coverages under a Component Plan are self-insured by the Employer, the benefits or coverage provided under the Component Plans may be paid solely from the general assets of the Employer. Nothing herein may be construed to require the Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant in the Plan or such Participant's Dependents, and no Participant, Dependent or other person has any claim against, right to or security or other interest in, any fund, account or asset of the Employer from which any self-insured benefit payment under the Plan may be made.

### **4.3 Limitation of Employer Liability**

To the extent certain benefits or coverages under a Component Plan are insured or accumulated in a trust to provide any benefits, liability for providing such benefits or coverages is solely that of the Insurer issuing the applicable Insurance Contract or the trust, as applicable. The Employer does not have any liability for any benefits due, or alleged to be due, under any applicable Insurance Contract.

### **4.4 Participant Contributions**

The University determines, in its sole discretion, the amount, if any, of Participant contributions required for the various levels of coverage applicable under a Component Plan. The University may initiate, or change the amount of, required Participant contributions for any coverage level under any Component Plan at any time. The Employer and/or Plan Administrator must provide notice of required Participant contributions to Participants prior to the beginning of each Plan Year, to the extent applicable, and must maintain a record of the payment of such contributions. Where applicable, required Participant contributions for coverage under a particular Component Plan must be paid by a Participant who is an Eligible Employee either through pre-tax pay reduction pursuant to Section 125 of the Code or through after-tax pay deduction, whichever is specified for such coverage under the Component Plan by the Employer and/or Plan Administrator. If the Participant does not have, or is not reasonably expected to have, cash pay sufficient to support the payment of required Participant contributions through the method specified by the Employer and/or Plan Administrator, the Participant

may pay such required Participant contributions through such other method, and in accordance with such rules and procedures, as the Employer and/or Plan Administrator may authorize.

## ARTICLE V ADMINISTRATION

### 5.1 Plan Administrator

- (a) **General:** The Plan Administrator, acting through the Vice President for Human Resources and Administration (or such other officer who assumes the functions and responsibilities of the Vice President for Human Resources and Administration), has the discretionary responsibility for the operation and administration of the Plan, including, but not limited to, those powers and duties set forth in Subsection (b) of this Section. The Plan Administrator may appoint such agents as it may deem necessary for the effective performance of its duties, and may delegate to such agents such powers and authority, whether ministerial or discretionary, as the Plan Administrator may deem expedient or appropriate. The compensation of such agents is fixed by the Plan Administrator within any limits set by the University. Any document required to be filed with, or any notice required to be given to, the Plan Administrator is properly filed or given if mailed or delivered to the Plan Administrator. Notwithstanding anything to the contrary contained herein, no individual acting as or on behalf of the Plan Administrator has any right to vote upon or decide any matter relating solely to himself or herself or to any of such member's rights or benefits under the Plan or any Component Plan; provided, however, such member may sign a unanimous written consent to resolutions adopted or other action taken without a meeting.
- (b) **Powers of the Plan Administrator:** The Plan Administrator has responsibility for, and all powers necessary or desirable to, control and manage the operation and administration of the Plan. The Plan Administrator has full discretionary power to administer the Plan in all of its details, subject to applicable requirements of law. To the extent the Plan Administrator delegates to one or more Claims Administrators authority to make claims determinations, such Claims Administrator has the same discretion as the Plan Administrator. The Plan Administrator's discretionary powers include, but are not limited to, the following discretionary authority, in addition to all other powers provided by the Plan:
- (1) adopt amendments to the Plan and any Component Plan which are required by a change in law, are administrative in nature or do not materially increase the cost of the Plan or such Component Plan;
  - (2) make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan and any Component Plan, including the establishment of any claims procedures that may be required by applicable provisions of law, provided that all rules, regulations and decisions of the Plan Administrator must be uniformly and consistently applied to all persons in similar circumstances;

- (3) construe and interpret the provisions of the Plan and any Component Plan (and the rules, procedures, forms and other documentation that it has created or approved for the Plan and any Component Plan), including, without limitation, by supplying omissions from, correcting deficiencies in, or resolving inconsistencies or ambiguities in, the language of the Plan and any Component Plan and consistent with the intent of the Plan or such Component Plan;
- (4) decide all questions concerning the Plan and any Component Plan, including, without limitation, factual questions and the eligibility of any person to participate in the Plan and any Component Plan;
- (5) compute the amount of benefits payable to any Participant, Dependent or other person in accordance with the provisions of the Plan and any Component Plan, and to determine the person or persons to whom such benefits are paid;
- (6) authorize the payment of benefits;
- (7) make any equitable adjustments to correct any error or omission discovered in the administration of any Component Plan;
- (8) require Participants to furnish such information as the Plan Administrator may require for the purpose of the proper administration of the Plan or any Component Plan as a condition to receiving benefits under the Plan or such Component Plan;
- (9) cause the Plan and any Component Plan to be administered in accordance with its terms;
- (10) make or approve rules, procedures, forms and other documentation for the administration and operation of the Plan and the Component Plans;
- (11) keep and maintain all records, books of accounts, data and documents that are necessary for the proper administration of the Plan and the Component Plans;
- (12) cause all required information to be disclosed to Participants and Beneficiaries concerning the Plan and the Component Plans;
- (13) select and designate the named fiduciaries of the Plan and the Component Plans and other service providers with respect to the Plan and the Component Plans, including trustees and agents as appropriate under the Plan and Component Plan;
- (14) monitor the general administration and maintenance of the Plan and any Component Plan, including legal and regulatory compliance;

- (15) cause all required reports, returns and documents for the Plan and any Component Plan to be filed with the appropriate governmental entities;
- (16) appoint such agents, who need not be employees of the University or its affiliates or members of the Plan Administrator, as it may deem necessary for the effective performance of its duties, and the Plan Administrator may delegate to those agents the powers and duties, whether ministerial or discretionary, that the Plan Administrator may deem expedient or appropriate;
- (17) create subcommittees of its members with such powers as it shall determine, which subcommittees may further delegate such duties to the extent not prohibited by the Plan Administrator, and which subcommittees shall report on their activities to the Plan Administrator from time to time in such manner as the Plan Administrator determines;
- (18) designate and allocate any responsibility to any other person or persons, including employees of the University, with such powers as it shall determine, which persons may further delegate such duties to the extent not prohibited by the Plan Administrator, and who shall report on their activities to the Plan Administrator from time to time in such manner as the Plan Administrator determines; and
- (19) carry out any other duties provided by any Plan document and exercise such other specific powers, authority and discretion as are expressly or by necessary implication conferred upon it.

Any determination by the Plan Administrator or its authorized delegate is final and binding in the absence of clear and convincing evidence that the Plan Administrator or delegate, as applicable, acted arbitrarily and capriciously.

- (c) **Records of Plan Administrator:** All proceedings, acts and determinations of the Plan Administrator are duly recorded in a minute book or other appropriate record and all such records, together with such other documents and data as may be necessary for the administration of the Plan, are preserved in the custody of the Plan Administrator.

## 5.2 Examination of Records

The Plan Administrator makes available to each Participant and Dependent such of the Participant's or Dependent's, as applicable, records under the Plan and any Component Plan that pertain to the Participant or Dependent, as applicable, for examination at reasonable times during normal business hours; provided, however, that the Plan Administrator has no obligation to disclose any records or information determined by the Plan Administrator, in its sole discretion, to be privileged or confidential.

### **5.3 Reliance by Plan Administrator**

- (a) **Reliance on Tables, Etc.:** In administering the Plan and any Component Plan, the Plan Administrator is entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by, or in accordance with the instructions or recommendations of, any delegate described in Section 5.1(b), or by any other experts employed or engaged by the Plan Administrator.
- (b) **Reliance on Participant's or Dependent's Certifications:** The Plan Administrator is entitled to rely conclusively on certifications and information provided by the Participant or the Participant's Dependent, unless the Plan Administrator has reason to believe that the Participant's or Dependent's certification or other information provided is incorrect.

### **5.4 Named Fiduciaries**

The Plan Administrator is a Named Fiduciary for purposes of Section 402(a)(1) of ERISA, with fiduciary responsibility for administration of the Component Plans and complying with all of the reporting and disclosure requirements of Part 1 of Subtitle B of Title I of ERISA, to the extent applicable. The University or the Plan Administrator may designate one or more other Named Fiduciaries with responsibility for carrying out the duties of the Employer under the Plan. Such individuals may change or designate additional Named Fiduciaries and allocate and reallocate fiduciary responsibilities. Any person may serve in more than one fiduciary capacity.

### **5.5 Allocation of Responsibilities**

The Named Fiduciaries may designate other persons who are not Named Fiduciaries to carry out such fiduciary responsibilities. The responsibilities imposed by the Plan on each Named Fiduciary are not joint responsibilities with any other fiduciary unless specifically so designated therein. No fiduciary is responsible for the act, or failure to act, of any other fiduciary.

### **5.6 Indemnification**

To the extent permitted under ERISA, the Plan indemnifies the University, the Plan Administrator, any Employee acting on behalf of the Plan Administrator and any fiduciary who is a director, officer, or other Employee of the Employer (an "Indemnified Party") against any cost or liability which they may incur in the course of administering the Plan, including any Component Plan, and executing the duties assigned pursuant to the Plan. The University indemnifies any Indemnified Party against any personal liability or cost not provided for in the preceding sentence which such Indemnified Party may incur as a result of any act or omission in relation to the Plan, or any Component Plan, or its Participants and/or Dependents. The University may purchase fiduciary liability insurance to insure its obligation under this Section. Promptly after receipt by an Indemnified Party under this Section of notice of a claim subject to indemnity hereunder, such Indemnified Party must, if a claim in respect thereof is to be made against the

University, notify the University of such claim. The University is entitled to participate at its own expense in the defense or to assume the defense, of any action brought against the Indemnified Party. In the event the University elects to assume the defense of any suit, the University may choose counsel which is reasonably satisfactory to the Indemnified Party to defend the action. The Indemnified Party must pay the fees and expenses of any additional counsel retained by such Indemnified Party.

## **5.7 Bonding**

Unless otherwise determined by the University, or unless required by any federal or state law, the Plan Administrator is not required to give bond or other security in any jurisdiction in connection with the administration of the Plan.

**ARTICLE VI  
CLAIMS AND REVIEW PROCEDURES**

**6.1 General**

- (a) **Authority of Claims Administrator:** Except as provided in Subsection (b) of this Section, the Claims Administrator has the authority to decide claims for benefits under the Component Plan, including denied claims on review, all in accordance with such claims procedure as it from time to time provides, which claims procedure must satisfy the requirements therefore that are imposed by ERISA and must be disclosed to Participants. The Plan Administrator delegates to the Claims Administrator acting under this Article the authority of the Plan Administrator as provided under Sections 5.1(b)(1) through (6).
- (b) **Authority of Plan Administrator:** Issues of whether an individual is eligible to participate in or obtain coverage under, or whether an eligible individual is enrolled for participation in or coverage under, the respective Component Plan or option under the Component Plan (collectively, “Eligibility and Enrollment Claims”), are determined by the Plan Administrator or its designee and review of denied determinations are determined by the Plan Administrator or its designee, all in accordance with the claims procedure set forth in this Article. Final appeals of claims for benefits under certain Component Plans are also determined by the Plan Administrator, or its designee, as specified in the applicable Incorporated Documents.
- (c) **No Designation of Claims Administrator:** If there has not been any designation of a Claims Administrator with respect to a Component Plan, all references to the Claims Administrator in this Article are deemed references to the Plan Administrator. The Claims Administrators are listed on Exhibit A.
- (d) **Compliance with Regulations:** Notwithstanding anything in this Article to the contrary, all claims under the Component Plans shall be administered in accordance with the timing and notice requirements specified in applicable Department of Labor regulations, as amended from time to time.
- (e) **Discretionary Authority:** Any construction or interpretation of the Plan’s or any Component Plan’s provisions or decisions that the Plan Administrator or Claims Administrator, as applicable, adopts in good faith (1) shall be binding upon all parties to or Beneficiaries of the Plan or Component Plan, subject only to any rights of review by the Plan Administrator or Claims Administrator, as applicable, provided by the Plan or Component Plan; (2) shall be given deference if subject to judicial review; and (3) shall be overturned only if arbitrary and capricious. In exercising their power and authority, the Plan Administrator and Claims Administrator shall apply uniform standards.
- (f) **Legal Action:** A Claimant may not bring a legal action against the Plan, any Component Plan, the Plan Administrator, any Claims Administrator or the



Employer relating to a claim unless and until the Claimant has followed the applicable claims procedures and exhausted the administrative remedies available under the Plan and the applicable Component Plan. No legal action may be brought more than one year following the earliest of the date of a final decision on the claim under these claims procedures, the date additional information to perfect the claim was required to be provided by the Claimant or the date a notice of demand was due. The one-year statute of limitations on suits applies in any forum where a Claimant initiates such suit or legal action. If a civil action is not filed within this period, the Claimant's claim will be deemed permanently waived and abandoned, and the Claimant will be precluded from reasserting it under these procedures or in a court or any other venue. A Claimant's authorized representative designated in accordance with the Component Plan's procedures, if any, may act on the Claimant's behalf in pursuing a claim or appeal of an adverse benefit determination.

## 6.2 Claims Procedures for Eligibility and Enrollment Claims

- (a) **Initial Claims:** Any Eligibility and Enrollment Claim must be received by the Plan Administrator within 60 days after the date on which the Claimant believes the eligibility or enrollment should have occurred. The Plan Administrator, in its sole discretion, will make all initial determinations regarding Eligibility and Enrollment Claims under the Plan and any Component Plan. The Plan Administrator will notify the Claimant of any adverse determination on an Eligibility and Enrollment Claim within a reasonable time after it is received, but not later than 60 days after receipt of the claim by the Plan Administrator unless the Plan Administrator determines, within its discretion, that special circumstances require an extension of time for processing the claim, in which case a written 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 60-day period. If an Eligibility and Enrollment Claim is denied, in whole or in part, the Plan Administrator will notify the Claimant in writing. The notice will include (1) the specific reason or reasons for the adverse determination; and (2) a description of the applicable review procedures and time limits established by the Plan Administrator.
  
- (b) **Appeals:** A Claimant may appeal an adverse determination on an Eligibility and Enrollment Claim to the Plan Administrator, which will make all determinations regarding the Eligibility and Enrollment Claim on appeal. If the Claimant wishes to appeal a denial of any part of the Eligibility and Enrollment Claim, the Claimant must appeal the denial to the Plan Administrator in writing within 60 days after the Claimant receives notice of the denial. If the Claimant fails to file an appeal for review within 60 days of the denial notification, the claim will be deemed permanently waived and abandoned, and the Claimant will be precluded from reasserting it under these procedures or in a court or any other venue. The appeal may include written comments, documents, records and other information relating to the Claimant's Eligibility and Enrollment 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 Eligibility and Enrollment Claim. The Plan Administrator will notify the Claimant in writing of its decision on the appeal within 60 days after receipt of the appeal. The notice will include the determination of the appeal and, if adverse, will contain the specific reason or reasons for the adverse determination of the appeal.

### 6.3 Claims Procedures for Determinations of Disability

#### (a) Initial Claim

(1) **Filing:** A Claimant may make a claim under a Component Plan providing benefits upon a determination of disability by filing a written claim with the Claims Administrator using the forms available from the Claims Administrator.

(A) **Notification of Claim Denial:** If a claim for benefits is denied, in whole or in part, the Claimant will receive a written notice from the Claims Administrator within a reasonable period of time, but no later than 45 days after it receives the claim. Under special circumstances, the Claims Administrator may take up to an additional 30 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the Claimant will be notified before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that an additional extension is necessary due to matters beyond its control, the Claims Administrator may take up to an additional 30 days to review the claim. If an additional extension of time is required, the Claimant will be notified before the end of the initial 30-day extension period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If the Claims Administrator extends its period for reviewing a claim due to special circumstances, the notice of extension the Claimant receives will include an explanation of the standards on which entitlement to benefits is based, the unresolved issues that prevent a decision on the claim and any additional information needed to resolve these issues. The Claimant has at least 45 days to provide the specified information.

(B) **Content of Notification of Denial:** If the disability claim is denied, in whole or in part, the Claims Administrator will notify the Claimant in writing. The notice will include:

- (i) the specific reason or reasons for the adverse determination;
- (ii) references to the specific Component Plan provisions on which the determination is based;
- (iii) a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
- (iv) a description of the Component Plan's review procedures 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 an adverse benefit determination on review;
- (v) a discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by the Claimant to the Component Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Component Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination and (c) a disability determination regarding the Claimant presented by the Claimant to the Component Plan and made by the Social Security Administration;
- (vi) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Component Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- (vii) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Component Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Component Plan do not exist; and
- (viii) 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:

In addition, any such notice of an adverse benefit determination will be provided in a culturally and linguistically appropriate manner.

(b) **Appeals**

(1) **Appeal of Denied Claim:** If the Claimant fails to file an appeal for review within 180 days of the denial notification, the claim will be deemed permanently waived and abandoned, and the Claimant will be precluded from reasserting it under these procedures or in a court or any other venue. If the Claimant wishes to appeal a denial of any part of the claim, the Claimant must appeal the denial to the Claims Administrator within 180 days after the Claimant receives notice of the denial. The request must be submitted in writing and must include:

- (A) the reasons why the Claimant feels the claim is valid; and
- (B) the reasons why the Claimant thinks the claim should not be denied.

Documents, records, written comments, and other information in support of the appeal should accompany the request. This information will be considered by the Claims Administrator in reviewing the claim. The Claimant may request to examine and receive copies of all documents, records, and other information relevant to the claim. The Claims Administrator will review the appeal without granting any deference to the initial decision regarding the claim. Also, no reviewer may be a person who was involved in making the initial decision regarding the claim, or subordinate to that person. In addition, if the claim was based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This person will not be a person or a subordinate of a person consulted by the Claims Administrator in deciding the initial claim. The Claims Administrator will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon or generated by the Component Plan, insurer or other person making the benefit determination (or at the direction of the Component Plan, insurer or such other person) in connection with the Claimant's appeal as soon as possible and sufficiently in advance of the date on which it provides the Claimant with notice of its determination on appeal, so that the Claimant will have a reasonable opportunity to respond prior to that date. In addition, if the denial of the Claimant's appeal is based on a new or additional rationale, the Claims Administrator will provide the Claimant, free of charge, with the new or additional rationale

as soon as possible and sufficiently in advance of the date on which it provides the Claimant with notice of its determination on appeal, so that the Claimant will have a reasonable opportunity to respond prior to that date.

- (2) **Notification of Appeal Decision:** The Claims Administrator will notify the Claimant of its decision on the appeal within 45 days after receipt of the appeal. Under special circumstances, the Claims Administrator may take up to an additional 45 days to review the appeal if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the Claimant will be notified in writing before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. The Claimant has at least 45 days to provide the specified information.
- (3) **Content of Notification of Appeal Decision:** If the appeal is denied, in whole or in part, the Claims Administrator will notify the Claimant in writing. The notice will include:
  - (A) the specific reason or reasons for the adverse determination;
  - (B) reference to the specific Component Plan provisions on which the benefit determination is based;
  - (C) 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;
  - (D) a statement describing any voluntary appeal procedures offered by the Component Plan and the Claimant's right to obtain information about those procedures;
  - (E) a statement about the Claimant's right to bring a civil action under Section 502(a) of ERISA and any applicable contractual limitations period that applies to the Claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires;
  - (F) a discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) the views presented by the Claimant to the Component Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Component Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making

the benefit determination and (iii) a disability determination regarding the Claimant presented by the Claimant to the Component Plan and made by the Social Security Administration;

- (G) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Component Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- (H) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Component Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Component Plan do not exist.

In addition, any such notice of an adverse benefit determination will be provided in a culturally and linguistically appropriate manner.

## 6.4 Claims Procedures for Group Health Plans

### (a) Initial Claim

#### (1) Urgent Care Claims

- (A) **Timing of Decision:** In the case of a claim involving urgent care under a Component Plan providing group health benefits, the Claims Administrator will review the claim and inform the Claimant in writing of its decision (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after it receives the claim.
- (B) **Additional Information:** If the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Component Plan, the Claims Administrator will inform the Claimant as soon as possible, but no later than 24 hours after it receives the claim, of the specific information necessary to complete the claim. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but no less than 48 hours, to provide the specified information. The Claims Administrator will notify the Claimant of its benefit determination as soon as possible, and no later than 48 hours after the earlier of:
  - (i) the Claims Administrator's receipt of the specified information; and

- (ii) the end of the period afforded to the Claimant to provide the specified additional information.
- (C) **Urgent Care Claim Defined:** For purposes of this Article, a “claim involving urgent care” is any claim for medical care or treatment with respect to which the application of time periods for making non-urgent care determinations:
  - (i) could seriously jeopardize the Claimant’s life or health or the Claimant’s ability to regain maximum function; or
  - (ii) in the opinion of a physician with knowledge of the Claimant’s medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

(2) **Pre-Service Claims**

- (A) **Timing of Decision:** In the case of a pre-service claim under a Component Plan providing group health benefits, the Claims Administrator will inform the Claimant of its decision (whether adverse or not) within a reasonable period of time appropriate to the medical condition, but not later than 15 days after it receives the claim. Under special circumstances, the Claims Administrator may take up to an additional 15 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the Claimant will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.
- (B) **Additional Information:** If additional information is needed because necessary information is missing from the request, the notice will specify what information is needed. The Claimant must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends a notice of missing information and the determination period will resume on the date the Claimant responds to the notice.
- (C) **Pre-Service Claim Defined:** For purposes of this Article, “pre-service claim” means any claim for a benefit under the Component Plan with respect to which the terms of the Component Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(3) **Post-Service Claims**

- (A) **Timing of Decision:** In the case of a post-service claim under a Component Plan providing group health benefits, the Claims Administrator will inform the Claimant of its decision within a reasonable period of time, but not later than 30 days after it receives the claim. Under special circumstances, the Claims Administrator may take up to an additional 15 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the Claimant will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.
- (B) **Additional Information:** If additional information is needed because necessary information is missing from the request, the notice will specify what information is needed. The Claimant must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends a notice of missing information and the determination period will resume on the date the Claimant responds to the notice.
- (C) **Post-Service Claim Defined:** For purposes of this Article, the term “post-service claim” means any claim for a benefit under a Component Plan that is not a pre-service claim or an urgent care claim.

(4) **Concurrent Care Decisions**

- (A) **Timing of Decision:** If a Component Plan providing group health benefits has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Component Plan of the course of treatment (other than by plan amendment or termination) before the end of the previously approved period of time or number of treatments will constitute a claim denial. If this occurs, the Claims Administrator will notify the Claimant of its decision at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a decision on appeal before the benefit is reduced or terminated.
- (B) **Special Rules for Urgent Care Claims:** Any request by the Claimant to extend the course of treatment beyond the previously approved period of time or number of treatments that constitutes a claim involving urgent care will be decided as soon as possible, taking into account the medical exigencies, and the Claims



Administrator will inform the Claimant of its decision (whether adverse or not) within 24 hours after it receives the claim, provided that the claim is made to the Claims Administrator at least 24 hours before the expiration of the prescribed period of time or number of treatments.

- (5) **Notice of Extension:** If the Claims Administrator extends its period for reviewing a claim due to special circumstances as described in this Subsection, the notice of extension that the Claimant receives will include:
- (A) an explanation of the standards on which entitlement to benefits is based;
  - (B) the unresolved issues that prevent a decision on the claim; and
  - (C) any additional information needed to resolve those issues.
- (6) **Content of Notification of Denial:** The Claimant will be notified in writing if any part of a claim for benefits under a Component Plan providing group health benefits is denied. This notice will include:
- (A) the specific reason or reasons for the denial;
  - (B) specific references to the pertinent Plan provisions on which the denial is based;
  - (C) a description of any additional information or materials necessary to process the claim properly and the reasons why the materials are needed;
  - (D) a description of the Plan's internal claims review process and the time limits applicable to such process, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;
  - (E) a statement that a copy of any internal rule, guideline, protocol or other similar criteria relied upon in making the adverse benefit determination is available free of charge upon request;
  - (F) a statement that if a denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limit, the Claims Administrator will, upon request, provide the Claimant, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical circumstances;

- (G) in the case of a denial concerning a claim involving urgent care, a description of the expedited review process applicable to such claims; and
- (H) with respect only to a Medical Plan claim:
  - (i) information sufficient to identify the claim involved;
  - (ii) notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
  - (iii) a description of the Medical Plan's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal; and
  - (iv) contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and the external appeals process.

In addition, any such appeal decision notification will be provided in a culturally and linguistically appropriate manner as required by ACA.

(b) **Appeals**

- (1) **Appeal of Denied Claim:** If the Claimant fails to file an appeal for review within 180 days of the denial notification, the claim will be deemed permanently waived and abandoned, and the Claimant will be precluded from reasserting it under these procedures or in a court or any other venue. If the Claimant wishes to appeal a denial of any part of a claim under a Component Plan providing group health benefits, the Claimant must appeal the denial to the Claims Administrator within 180 days after the Claimant receives notice of the denial. The request must be submitted in writing and must include:

- (A) the reasons why the Claimant feels the claim is valid; and
- (B) the reasons why the Claimant thinks the claim should not be denied.

Documents, records, written comments, and other information in support of the appeal should accompany the request. The Claimant may request to examine and receive copies of all documents, records, and other information relevant to the claim.

- (2) **Review of Appeal:** Any information provided by the Claimant in connection with the appeal will be considered by the Claims Administrator in reviewing the claim. The Claims Administrator will review the claim without granting any deference to the initial decision regarding the claim. Also, no reviewer may be a person who was involved in making the initial decision regarding the claim, or a subordinate to that person. In addition, if the denial of the claim was based, in whole or in part, on a medical judgment in reviewing the claim, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment in reviewing the claim. This person will not be a person or a subordinate of a person consulted by the Claims Administrator in deciding the initial claim.
- (3) **Appeal of a Medical Plan Claim:** With respect to Medical Plan claims, the Claimant will be allowed to review the claim file and to provide evidence and testimony as part of the internal claims and appeals process. The applicable Medical Plan Claims Administrator will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon or generated by the Medical Plan (or at the direction of the Medical Plan) in connection with the Claimant's appeal as soon as possible and sufficiently in advance of the date on which it provides the Claimant with notice of its determination on appeal, so that the Claimant will have a reasonable opportunity to respond prior to that date. In addition, if the denial of the Claimant's appeal is based on a new or additional rationale, the applicable Medical Plan Claims Administrator will provide the Claimant, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides the Claimant with notice of its determination on appeal, so that the Claimant will have a reasonable opportunity to respond prior to that date.
- (4) **Notification of Appeal Decision**
- (A) **Urgent Care Claims:** In the case of a claim involving urgent care, the Claims Administrator will provide this notice as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the request for review.
- (B) **Pre-Service Claims:** In the case of a pre-service claim, the Claims Administrator will provide this notice within a reasonable amount of time appropriate to the medical circumstances but not later than 30 days after receipt of the request for review if the Component Plan provides for only one mandatory appeal of an adverse benefit determination or within 15 days for each appeal if the Component Plan provides for two mandatory appeals of an adverse determination.

- (C) **Post-Service Claims:** In the case of a post-service claim, the Claims Administrator will provide this notice within a reasonable amount of time but not later than 60 days after receipt of the request for review if the Component Plan provides for only one mandatory appeal of an adverse benefit determination or within 30 days for each appeal if the Component Plan provides for two mandatory appeals of an adverse determination.
  - (D) **Concurrent Care Claims:** In the case of a concurrent care claim, the Claims Administrator will provide this notice within a reasonable amount of time appropriate to the medical circumstances but not later than 15 days after receipt of the request for review for each level of the Claimant's appeal.
- (5) **Content of Appeal Denial:** The notice provided for all appeal denials under a Component Plan providing group health benefits will include:
- (A) the specific reason or reasons for the denial;
  - (B) specific references to the pertinent Plan provisions on which the denial is based;
  - (C) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
  - (D) a statement about the Claimant's right to bring a civil action under Section 502(a) of ERISA following any final internal adverse benefit determination;
  - (E) a statement that a copy of any internal rule, guideline, protocol or other similar criteria relied upon in making the adverse benefit determination is available free of charge upon request;
  - (F) a statement that if a denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limit, the Claims Administrator will, upon request, provide the Claimant, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical circumstances; and
  - (G) with respect only to a Medical Plan claim:
    - (i) information sufficient to identify the claim involved;
    - (ii) notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved,

including their respective meanings, and to have such information provided upon request;

- (iii) a description of the Medical Plan's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal; and
- (iv) contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and the external appeals process.

In addition, any such appeal decision notification will be provided in a culturally and linguistically appropriate manner as required by ACA.

Also, upon request, the Claims Administrator will provide the Claimant with a statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.

- (6) **Medical Plan External Review Process:** External review is available only for certain types of adverse benefit determinations, as defined by federal regulations and other applicable guidance, and the provisions of this Paragraph apply only to those adverse benefit determinations. Each Medical Plan option will comply with applicable federal regulations regarding external review. Not in limitation, but in amplification of the preceding sentence, any fully-insured Medical Plan option will comply with any applicable state external review process that meets, at a minimum, the consumer protections set forth in federal regulations. Any fully-insured Medical Plan option not subject to such a state external review process and each self-insured Medical Plan option will comply with the federal external review process outlined in federal regulations and other applicable guidance, and described in the remainder of this Paragraph.
  - (A) **Eligibility for External Review:** A Claimant who receives a notice of an adverse benefit determination and who exhausts a Medical Plan option's internal claims and appeals process within the meaning of applicable federal regulations may file an appeal with an independent review organization (IRO) that is accredited to conduct a review of the Claimant's claim.
  - (B) **Timing for Filing External Appeal:** A Claimant must submit a request for external review to the applicable Claims Administrator within four months of the date of the Claimant's receipt of the Claimant's final internal adverse benefit determination on appeal. If the Claimant fails to submit a request for external review by

such deadline, the claim will be deemed permanently waived and abandoned, and the Claimant will be precluded from reasserting it under these procedures.

- (C) **Notification of Eligibility of Appeal for External Review:** The applicable Claims Administrator will determine if the Claimant's appeal is eligible for the voluntary external review process and will provide the Claimant with a written notice of its determination. If the Claimant's request is complete but not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Department of Labor Employee Benefits Security Administration. If the Claimant's request for external review is not complete, the notice will describe the information or materials needed to make the request complete. The Claimant must provide the required information to the applicable Claims Administrator within the original four-month filing period or within the 48-hour period following receipt of the notification, whichever is later. If the Claimant fails to provide the required information by the applicable deadline, the claim will be deemed permanently waived and abandoned, and the Claimant will be precluded from reasserting it under these procedures.
  
- (D) **IRO Review of Claim:** If the Claimant's claim is eligible for external review, the applicable Claims Administrator will assign the claim to an IRO. The IRO will notify the Claimant of the acceptance of the claim for external review and the Claimant's right to submit to the IRO in writing within 10 business days following receipt of the notice any additional information the IRO should consider in conducting the external review. The IRO will review all of the information and documents it receives in a timely manner as outlined in federal regulations and other applicable guidance.
  
- (E) **Notification of IRO Decision:** The IRO will provide written notice to the Claimant and the applicable Medical Plan option of the final external review decision within 45 days after the IRO receives the request for external review. The notice will include the following:
  - (i) a general description of the reason for the request for external review, including information sufficient to identify the claim;
  
  - (ii) the date the IRO received the assignment to conduct the external review and the date of the IRO decision;

- (iii) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, the IRO considered in reaching its decision;
  - (iv) a discussion of the principal reason or reasons for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
  - (v) a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to the Claimant or the applicable Medical Plan option;
  - (vi) a statement that judicial review may be available to the Claimant; and
  - (vii) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.
- (F) **External Review of Urgent Care Claims:** If the Claimant's request for external review relates to an urgent care claim, the applicable Claims Administrator will determine if the appeal is eligible for the voluntary external review program and will provide the Claimant with written notice of its determination immediately. If the urgent care claim is eligible for external review, the Claims Administrator will assign the urgent care claim to an IRO as described in Subparagraph (D) of this Paragraph. The IRO will review all of the information and documents relevant to the appeal, to the extent the information and documents are available and the IRO considers them appropriate. The IRO will provide notice to the Claimant and the applicable Medical Plan option of the final external review decision as soon as possible, but no more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not provided in writing, within 48 hours after the date of providing the notice, the IRO will provide the Claimant and the applicable Medical Plan option with a written confirmation of its decision.

## 6.5 Claims Procedures for Other Plans

- (a) **Initial Claim:** To receive or apply for benefits under any Component Plan not specifically described in Sections 6.3 or 6.4, the Claimant must submit initial claims and/or appeals, as applicable, in accordance with this Section.
  - (1) **Notification of Claim Denial:** If the claim for benefits is denied, in whole or in part, the Claimant will receive a written notice from the Claims

Administrator within 90 days. Under special circumstances, the Claims Administrator may take up to an additional 90 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the Claimant will be notified before the end of the initial 90-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

(2) **Content of Notification of Denial:** If the claim is denied, in whole or in part, the Claims Administrator will notify the Claimant in writing. The notice will include:

- (A) the specific reason or reasons for the denial;
- (B) specific references to the pertinent Plan provisions on which the denial is based;
- (C) a description of any additional information or materials necessary to perfect the claim and an explanation of why such material or information is needed; and
- (D) an explanation of the claims review process and the time limits applicable to such process, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

(b) **Appeals**

(1) **Appeal of Denied Claim:** If the Claimant fails to file an appeal for review within 60 days of the denial notification, the claim will be deemed permanently waived and abandoned, and the Claimant will be precluded from reasserting it under these procedures or in a court or any other venue. If the Claimant wishes to appeal a denial of any part of a claim, the Claimant must appeal the denial to the Claims Administrator within 60 days after the Claimant receives notice of the denial. The request must be submitted in writing and must include:

- (A) the reasons why the Claimant feels the claim is valid; and
- (B) the reasons why the Claimant thinks the claim should not be denied.

Documents, records, written comments, and other information in support of the appeal should accompany the request. This information will be considered by the Claims Administrator in reviewing the claim. The Claimant may request to examine and receive copies of all documents, records, and other information relevant to the claim.



- (2) **Notification of Appeal Decision:** The Claims Administrator will review the appeal and inform the Claimant in writing of its decision within a reasonable period of time, but no later than 60 days after it receives the appeal. Under special circumstances, the Claims Administrator may take up to an additional 60 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the Claimant will be notified before the end of the initial 60-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.
- (3) **Content of Appeal Denial:** If the claim is denied on appeal, the Claimant will receive written notice of the denial. The notice will include:
- (A) the specific reason or reasons for the denial;
  - (B) specific references to the pertinent Plan provisions on which the denial is based;
  - (C) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and
  - (D) a statement about the Claimant's right to bring a civil action under Section 502(a) of ERISA.

**ARTICLE VII  
AMENDMENT OR TERMINATION**

**7.1 Amendment**

- (a) The University reserves without limitation the right to amend, modify or change the Plan and/or any Component Plan in whole or in part at any time and from time to time as follows:
  - (1) by action of the Yale Corporation; or
  - (2) by action of the Vice President for Human Resources and Administration (or such other officer who assumes the functions and responsibilities of the Vice President for Human Resources and Administration) to comply with changes in law, to reflect changes that are administrative in nature or to effectuate changes that do not materially increase the cost of the Plan or such Component Plan.
- (b) Any amendment to the Plan may affect not only active Employees (and their Dependents), but also former active Employees who retired, became disabled, died or whose employment with the Employer has otherwise terminated (and their Dependents), and also any Participant (and such Participant's Dependents) who began receiving benefit coverage or payments prior to the amendment. The University reserves the right to amend, modify or change retiree coverage offered under the Plan at any time.
- (c) All amendments must be made in writing; provided, however, that amendments to the Plan and/or any Component Plan can be effectuated by the publication and distribution by the Vice President for Human Resources and Administration (or such other officer who assumes the functions and responsibilities of the Vice President for Human Resources and Administration) of written materials, such as the annual enrollment materials or other written materials authorized by the Vice President for Human Resources and Administration (or an officer or Employee who has delegated authority from the Vice President for Human Resources and Administration to perform this function), designed to communicate the changes. These written materials shall be attached as an Appendix to the Plan and their provisions shall be incorporated in the Plan by this reference.
- (d) Except as provided in Subsection (c) of this Section, written or oral statements or representations by the Employer, the Plan Administrator and/or their agents are insufficient to modify the terms of the Plan and/or any Component Plan.

**7.2 Termination**

- (a) **Right to Terminate:** The University has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the University has no obligation to maintain the Plan for any given length of time, and the University reserves without limitation the right to terminate the Plan and/or any

Component Plan at any time with or without reason by action of the Yale Corporation or an authorized delegate. Such decision to terminate the Plan and/or any Component Plan must be made in writing.

- (b) **Payment of Claims Upon Termination:** In the event the Plan and/or any Component Plan is terminated, the Employer has no further liability to pay any benefits pursuant to the Plan or Component Plan, as applicable, with respect to any period after such termination. The Plan and/or any Component Plan, as applicable, will continue until all proper pending claims for benefits outstanding as of the date of termination have been paid.

**ARTICLE VIII  
HIPAA PRIVACY AND SECURITY**

**8.1 General HIPAA Provision**

- (a) **Hybrid Entity Designation:** The University designates the Plan as a hybrid entity in accordance with 45 CFR Section 164.105 and only those Component Plans that would be a covered health plan under 45 CFR Section 160.103 constitute the health care components of the Plan. Any Component Plan that would not be a covered health plan under 45 CFR Section 160.103 if provided through a separate plan is a non-health care component of a hybrid entity and is not subject to 45 Code of Federal Regulations Part 160, Subparts A and E (the “Privacy Rule”) or 45 Code of Federal Regulations Part 160 and 164, Subparts A and C (the “Security Rule”). Component Plans that are subject to the Privacy Rule and/or the Security Rule are referred to as the “HIPAA Plans.” The Employer must comply with the requirements of the Privacy Rule and the Security Rule, as applicable, with respect to the HIPAA Plans.
- (b) **Organized Health Care Arrangement Designation:** The Plan Administrator intends the Plan to form part of an Organized Health Care Arrangement along with any other benefit under a covered health plan (under 45 CFR Section 160.103) provided by the Employer.

**8.2 HIPAA Privacy Provisions**

- (a) **Protected Health Information:** The HIPAA Plans use and disclose Protected Health Information (referred to as “PHI”) as permitted or required by HIPAA. PHI generally means information that:
  - (1) is transmitted or maintained by the HIPAA Plans;
  - (2) relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual; and
  - (3) identifies the individual or for which there is a reasonable basis to believe that the information could be used to identify the individual.
- (b) **Disclosures of PHI to Employer:** The HIPAA Plans may disclose PHI to the Employer only as permitted below or as otherwise required or permitted by HIPAA or other applicable law. Notwithstanding any provision of the HIPAA Plans to the contrary, in no event is the Employer permitted to use or further disclose PHI in a manner that is inconsistent with 45 CFR Section 164.504(f).
  - (1) **Participation Information:** The HIPAA Plans may disclose to the Employer information regarding whether an individual is participating in a HIPAA Plan.

- (2) **Summary Health Information:** Except as prohibited by 45 CFR Section 164.502(a)(5)(i), the HIPAA Plans may disclose Summary Health Information to the Employer if the Employer requests the Summary Health Information for the purpose of modifying, amending or terminating a HIPAA Plan. “Summary Health Information” means information, which may be individually identifiable health information, and:
    - (A) summarizes the claims history, claims expenses or types of claims experienced by individuals for whom the Employer has provided health benefits under a HIPAA Plan; and
    - (B) from which the information described at 45 CFR Section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR Section 164.514(b)(2)(i)(B) need only be aggregated to the level of a 5-digit zip code.
  - (3) **Plan Administration Functions:** Subject to the conditions of disclosure and written certification requirements described below, the HIPAA Plans may disclose PHI to the Employer to allow the Employer to perform plan administration functions on behalf of the HIPAA Plans. The Employer may access and use such PHI for plan administration functions that include claims processing, quality assurance, auditing, monitoring, and other activities that would constitute “payment” and “health care operations” as those terms are defined under HIPAA. Plan administration functions do not include any functions performed by the Employer in connection with any other benefit or employee benefit plan of the Employer or any employment-related functions performed by the Employer.
- (c) **Conditions of Disclosure for Plan Administration Functions:** With respect to PHI disclosed to the Employer by the HIPAA Plans (other than participation information and Summary Health Information which may be used and disclosed as described in Subsection (b) of this Section), the Employer agrees to the conditions described in this Subsection.
- (1) The Employer may not use or further disclose PHI other than as permitted or required by the HIPAA Plans or as required by law.
  - (2) The Employer must ensure that any agent to whom it provides PHI received from the HIPAA Plans agrees to the same restrictions and conditions that apply to the Employer with respect to such PHI.
  - (3) The Employer may not use or disclose PHI for employment-related actions and decisions or in connection with any other benefits or employee benefit plan of the Employer, except to the extent a use or disclosure may otherwise be permitted by HIPAA or pursuant to an authorization that complies with 45 CFR Section 164.508.

- (4) If the Employer becomes aware of any use or disclosure of PHI by the Employer that is inconsistent with the uses or disclosures permitted in this Section, the Employer must report such use or disclosure of PHI to the HIPAA Plans.
  - (5) The Employer must make PHI available to comply with an individual's right to access the individual's PHI in accordance with 45 CFR Section 164.524.
  - (6) The Employer must make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526.
  - (7) The Employer must make available the information required to provide an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.
  - (8) The Employer must make its internal practices, books and records relating to the use and disclosure of PHI received from the HIPAA Plans available to the Secretary of the Department of Health and Human Services for purposes of determining the HIPAA Plans' compliance with 45 CFR Part 164, Subpart E.
  - (9) When PHI that the Employer received from the HIPAA Plans is no longer needed for the purpose for which the disclosure was made, the Employer must, if feasible, return or destroy all such PHI that the Employer still maintains in any form and retain no copies of such information. If such return or destruction is not feasible, the Employer must limit further uses and disclosures to those purposes that make the return or destruction of PHI infeasible.
  - (10) The Employer must ensure adequate separation between the Employer and the HIPAA Plans as required by 45 CFR Section 164.504(f)(2)(iii).
- (d) **Adequate Separation Between HIPAA Plans and Employer:** The Employer ensures adequate separation between the HIPAA Plans and the Employer as required by 45 CFR Section 164.504(f)(2)(iii) as described in this Subsection.
- (1) The Employer causes the HIPAA Plans to adopt policies and procedures regarding permissible disclosures of PHI to the Employer for plan administration purposes or other lawful purposes; and
  - (2) The Employer may allow only designated Employees to be given access to PHI. Such Employees may have access to and use PHI only to the extent necessary to conduct the plan administration functions that the Employer performs for the HIPAA Plans. Any such Employee who does not comply with this Section is subject to disciplinary action by the Employer based on the severity of the violation and in accordance with the Employer's employee disciplinary policies. If the Employee's noncompliance results

in an unauthorized use or disclosure of PHI, the Employer must report the unauthorized use or disclosure to the HIPAA Plans. The Employer also must, to the extent practicable, take steps to mitigate any harmful effect known to the Employer that arises from such Employee's noncompliance.

- (e) **Certification of the Employer:** The HIPAA Plans may disclose PHI to the Employer only upon the receipt of a certification by the Employer that the applicable HIPAA Plan has been amended to incorporate the provisions of 45 CFR Section 164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Subsection (c) of this Section.
- (f) **Privacy Official:** The Plan must designate a Privacy Official, who is responsible for the HIPAA Plans' compliance with the Privacy Rule. The Privacy Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third party experts as the Privacy Official deems necessary or advisable. In addition, and notwithstanding any provision of the HIPAA Plans to the contrary, the Privacy Official, or the Privacy Official's designee, has the authority to and is responsible for:
  - (1) accepting and verifying the accuracy and completeness of any certification provided by the Employer under this Article;
  - (2) transmitting the certification to any third parties as may be necessary to permit them to disclose PHI to the Employer;
  - (3) establishing and implementing policies and procedures with respect to PHI that are designed to ensure compliance by the HIPAA Plans with the Privacy Rule;
  - (4) establishing and overseeing proper training of Employer personnel who have access to PHI; and
  - (5) any other duty or responsibility that the Privacy Official, in the Privacy Official's sole capacity, deems necessary or appropriate to comply with the Privacy Rule.

### 8.3 HIPAA Security Provisions

- (a) **Electronic PHI:** Electronic PHI generally means PHI that is:
  - (1) maintained in electronic storage media on which data is or may be recorded electronically, including, for example, devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk or digital memory card; or
  - (2) transmitted by transmission media including the Internet, extranet or intranet, leased lines, dial up lines, private networks and the physical movement of removable/transportable electronic storage media. Certain

transmissions, including of paper, via facsimile and of voice via telephone, are not considered to be transmissions via electronic media if the PHI being exchanged did not exist in electronic form immediately before the transmission.

- (b) **Conditions on Disclosure of Electronic PHI to Employer:** With respect to Electronic PHI disclosed to the Employer by the HIPAA Plans (other than participation information and Summary Health Information as described in Section 8.2), the Employer agrees to the conditions described in this Subsection.
- (1) The Employer must implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the HIPAA Plans.
  - (2) The Employer must ensure that the adequate separation between the HIPAA Plans and the Employer as described in Section 8.2(d) is supported by reasonable and appropriate administrative, physical and technical safeguards.
  - (3) The Employer must ensure that any agent to whom it provides Electronic PHI agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the Electronic PHI.
  - (4) The Employer must report to the HIPAA Plans any Security Incident of which it becomes aware. A Security Incident is the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system (an interconnected set of information resources under the same direct management control that shares common functionality that typically includes hardware, software, information, data, applications, communications and people).
- (c) **Security Official:** The HIPAA Plans must designate a Security Official, who is responsible for the HIPAA Plans' compliance with the Security Rule. The Security Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third party experts as the Security Official deems necessary or advisable. In addition, and notwithstanding any provision of the HIPAA Plans to the contrary, the Security Official, or the Security Official's designee, has the authority to and is responsible for:
- (1) accepting and verifying the accuracy and completeness of any certification provided by the Employer under this Article;
  - (2) transmitting the certification to any third parties as may be necessary to permit them to disclose Electronic PHI to the Employer;



- (3) establishing and implementing policies and procedures with respect to Electronic PHI that are designed to ensure compliance by the HIPAA Plans with the Security Rule;
- (4) establishing and overseeing proper training of Employer personnel who have access to Electronic PHI; and
- (5) any other duty or responsibility that the Security Official, in the Security Official's sole capacity, deems necessary or appropriate to comply with the Security Rule.

#### **8.4 Interpretation and Limited Applicability**

This Article serves the sole purpose of complying with the requirements of HIPAA and must be interpreted and construed in a manner to effectuate this purpose. Neither this Article nor the duties, powers, responsibilities and obligations listed herein may be taken into account in determining the amount or nature of the benefits provided to any person covered under the HIPAA Plans, nor may they inure to the benefit of any third parties. To the extent that any of the provisions of this Article are not required by HIPAA, they are deemed deleted and have no further force or effect.

#### **8.5 Services Performed for the Employer**

Notwithstanding any other provision of the HIPAA Plans to the contrary, all services performed by a business associate of the HIPAA Plans in accordance with the applicable services agreement are deemed to be performed on behalf of the HIPAA Plans and subject to the Privacy Rule and the Security Rule, except services that relate to eligibility and enrollment in the HIPAA Plans. If a business associate of the HIPAA Plans performs any services that relate to eligibility and enrollment in the HIPAA Plans, those services are deemed to be performed on behalf of the Employer in its capacity as Plan sponsor and not on behalf of the HIPAA Plans.

**ARTICLE IX  
MISCELLANEOUS**

**9.1 Exclusive Benefit**

The Plan is maintained for the exclusive benefit of Eligible Employees and their Dependents.

**9.2 Limitation of Rights**

Neither the establishment of the Plan nor any provision or amendment thereof will be construed as giving any Participant or other person any legal or equitable right against any Employer, its officers or Employees, or the Plan Administrator, except as expressly provided herein or by law, or to create a contract of employment with any Participant, to obligate the Employer to continue the service of any Eligible Employee or to affect or modify the Eligible Employee's terms of employment in any way.

**9.3 No Vested Rights**

No Employee of the Employer, whether or not a Participant in, or eligible to participate in, the Plan has at any time any vested rights to benefits provided under the Plan or any Component Plan. All benefits provided to Eligible Employees and anyone claiming benefits through Eligible Employees are not vested and are subject to amendment, modification, change and termination by the University at any time with or without reason.

**9.4 Corporate Action**

Any action required to be taken by the Employer under the Plan may be taken by any officer of the Employer acting under authority of the Employer's board of directors, as constituted from time to time, or comparable governing body charged with management of the organization, unless otherwise specified or delegated.

**9.5 Right of Recovery**

The Plan has the right to recover any payment it made but should not have made or made to an individual or organization not entitled to payment, from the individual or organization or anyone else benefiting from the improper payment or to deduct the amount of such payment from any future payments to, or for, the Participant.

**9.6 Subrogation and Reimbursement**

The Plan does not provide primary coverage for expenses associated with an injury or illness caused or worsened by the action of any third party which gives rise to a claim against that party, nor does it provide primary coverage for such expenses to the extent that there is other applicable coverage from a source other than the Plan (including, but not limited to, medical benefits under an automobile insurance policy). In the event that an individual receiving benefits under the Plan ("Covered Individual") sustains an injury

or illness as a result of an action of a third party, and the Plan pays for costs associated with such injury or illness, the Plan has the rights of subrogation and reimbursement described in this Section.

- (a) **Subrogation Rights:** The Plan has the right to be subrogated to the Covered Individual's rights against any third parties which arise from such injury or illness.
- (b) **Reimbursement Rights:** The Plan has the right to be fully reimbursed (to the extent of benefits paid) by the Covered Individual if such Covered Individual obtains any financial recovery from any source, including such Covered Individual's own insurance carrier or another welfare benefit plan (such as a disability plan, if any) sponsored by the Employer, whether by judgment, settlement, award, government or worker's compensation benefits, or otherwise, on account of such injury or illness, and the Plan has a lien on any such recovery. Also, by accepting benefits under the Plan in connection with such an injury or illness, the Covered Individual assigns any recovery to the Plan and authorizes such Covered Individual's attorney, personal representative or Insurance Company to reimburse the Plan. The Plan is entitled to full reimbursement:
  - (1) before the Covered Individual is entitled to retain any part of such financial recovery, regardless of the stated reason for the financial recovery or whether the Covered Individual has other costs or suffered other injuries not paid for or compensated by the Plan (notwithstanding any "Make Whole Doctrine");
  - (2) without regard to any claim of fault on the part of the Covered Individual, whether under comparative negligence or otherwise;
  - (3) without reduction for attorneys' fees and other costs incurred by the Participant or Dependent in making a recovery without the prior express written consent of the Plan (notwithstanding any "Fund Doctrine," "Common Fund Doctrine," or "Attorneys' Fund Doctrine"); and
  - (4) notwithstanding that the recovery to which the Plan is subrogated is paid to a decedent, a minor, a decedent's estate, or an incompetent or disabled person.
- (c) **Requirements for Covered Individuals to Receive Benefits:** Notwithstanding any other provision of the Plan to the contrary, the payment of benefits under the Plan on account of an injury or illness as a result of an action of a third party is contingent on the Covered Individual:
  - (1) informing the Plan Administrator of the action to be taken by the Covered Individual;
  - (2) agreeing (in such form and to such documents as the Plan may require) to the Plan being reimbursed from any recovery from a third party and

subrogated to any right of recovery the Covered Individual has against a third party;

- (3) refraining from action which would prejudice the Plan's subrogation rights (including, but not limited to, making a settlement which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan); and
- (4) cooperating in doing what is reasonably necessary to assist the Plan in any recovery.

If the Covered Individual should fail or refuse to comply with this Section, the Covered Individual is not entitled to benefits under the Plan and must reimburse the Plan for any and all costs and expenses, including attorneys' fees, incurred by the Plan in enforcing its rights hereunder. The Plan may determine not to exercise all of the reimbursement and/or subrogation rights described in this Section in certain types of cases, with respect to certain covered groups, or with respect to certain geographic areas, without waiving its right to enforce its rights in the future as to other groups or in other geographic areas.

#### **9.7 Incorrect Information, Fraud, Concealment, or Error**

- (a) **Right to Recover Payments:** Notwithstanding anything in the Plan to the contrary, the Plan Administrator shall be entitled to recover, in any manner the Plan Administrator in its sole discretion deems necessary or appropriate for such recovery, from a Participant, Dependent, Beneficiary or other individual any or all of any benefits paid or the amount of any liability incurred and any and all expenses incidental to or necessary for such recovery if, because of a human or systems error, or because of the provision of incorrect information or the failure to provide correct information, fraud, misrepresentation, or concealment of any relevant fact (determined in the sole discretion of the Plan Administrator) by the Participant, Dependent, Beneficiary, or other individual, the Plan:
  - (1) enrolls any individual in a Component Plan, provides COBRA Continuation Coverage to any individual pursuant to Section 2.4, or pays a benefit claim under the Plan or a Component Plan;
  - (2) incurs a liability for failure to so enroll, provide COBRA Continuation Coverage, or pay a benefit claim;
  - (3) incurs a liability for terminating enrollment or COBRA Continuation Coverage; or
  - (4) makes any payment, overpayment or erroneous payment to any individual or entity.
- (b) **Right to Terminate Participation or Take Other Appropriate Action:** Notwithstanding anything in the Plan to the contrary, the Plan Administrator will be entitled to terminate, suspend or otherwise alter the participation of any

Participant, Dependent or other individual in the Plan and/or any applicable Component Plan, to the extent permitted by applicable law, and to take other appropriate action as determined in its sole discretion, if any of the following events occur:

- (1) the Participant, Dependent or other individual omits, misrepresents, or provides materially false information to the Plan in connection with enrollment in or ongoing participation in the Plan or a Component Plan;
- (2) the Participant, Dependent or other individual permits an individual who is not covered under a Component Plan to use a Component Plan's identification card or to falsely obtain benefits under the Plan or a Component Plan; or
- (3) the Participant, Dependent or other individual obtains or attempts to obtain benefits under the Plan or a Component Plan by means of false, misleading or fraudulent information, acts or omissions.

## **9.8 Nonassignment of Rights**

A Participant's or Dependent's right to receive any reimbursement under a Component Plan is not alienable by the Participant or Dependent by assignment or any other method except as expressly permitted under the applicable Component Plan, and is not subject to be taken by the Participant's or Dependent's creditors by any process whatsoever, and any attempt to cause such right to be so subjected is not recognized, except to such extent as may be required by law.

## **9.9 No Guarantee of Tax Consequences**

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts deposited or credited on behalf of, paid to or on behalf of, or reimbursed to or on behalf of any Participant under the Plan are excludable from the Participant's gross income for federal, state or local income tax purposes, or that any other federal, state or local tax treatment applies to or is available to any Participant. Each Participant is obligated to determine whether each payment under the Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. If for any reason it is determined that any amount paid for the benefit of a Participant or the Participant's Dependent are includable in a Participant's gross income for federal, state or local income tax purposes, then under no circumstances does the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Participant as a result thereof.

## **9.10 Withholding Taxes**

To the extent that the Employer is required to withhold federal, state, local or foreign taxes in connection with any payment made to a Participant under a Component Plan, the

Employer may withhold the amount so determined from the payment, or the Participant may pay the amount so determined in any other manner permitted by the Plan Administrator.

### **9.11 Indemnification of Employer by Participants**

If a Participant receives benefits under the Plan that do not qualify for exclusion from income under Section 105 of the Code or any other relevant provision of the Code, and the receipt of such benefit was due to the negligent or intentional act or failure to act by the Participant or the Participant's Dependent in applying for or obtaining such benefit, then the Participant must indemnify and reimburse the Employer for any taxes and other expenses incurred by the Employer due to that nonqualified benefit.

### **9.12 Information to be Furnished**

Eligible Employees must provide the Plan Administrator and the Claims Administrator with such information and evidence, and must sign such documents, as may be requested by the Plan Administrator and/or the Claims Administrator from time to time for the purpose of administration of the Plan.

### **9.13 Notices and Elections**

All notices and elections required to be given or made by a Participant, Dependent or Beneficiary (including requests, directions, consents, designations and applications) under any provision of any Component Plan, are invalid unless made in the form and in accordance with the procedure prescribed by the Plan Administrator and delivered in a timely and proper manner to the Plan Administrator.

### **9.14 Incapacity to Receive Payment**

In the event that the Plan Administrator or its delegate finds that any Participant, Dependent or Beneficiary entitled to receive benefits hereunder is, at the time such benefits are payable, unable to care for the Participant's, Dependent's or Beneficiary's, as applicable, affairs because of a physical, mental, or legal incompetence, the Plan Administrator or its delegate may, in its sole discretion, cause any payment due the Participant, Dependent or Beneficiary, as applicable, for which prior claim has not been made by a duly qualified guardian or other legal representative, to be paid to such one or more persons as may be chosen by the Plan Administrator or its delegate from among the following: the institution maintaining or responsible for the maintenance of such Participant, Dependent or Beneficiary, the Participant's Spouse, the Participant's Child(ren) or other relative by blood or marriage. Any payment made pursuant to this Section is a complete discharge of all liability under the Plan with respect of such payment.

### **9.15 Failure to Cash Check**

With respect to any self-insured Component Plan, if payment for benefits is made to a Claimant in the form of a check, and such check is not cashed within one year from its

date of issuance, then such payment reverts to the Component Plan's trust or, if none, to the Employer.

#### **9.16 Payment of Expenses**

The Employer may, but does not obligate itself to, pay all or part of the expenses of administration of the Component Plans and the expenses of the Plan Administrator, and any other expenses incurred at the direction of the Plan Administrator.

#### **9.17 Disclosures via Other Media**

The Plan Administrator and/or Claims Administrator may, in its sole discretion, use any electronic or other alternative media form that it deems necessary or appropriate to meet ERISA reporting and disclosure requirements applicable to the Plan in accordance with ERISA.

#### **9.18 Qualified Medical Child Support Orders**

Medical benefits under the Plan must be administered in accordance with the provisions of any qualified medical child support order to which the Plan is subject, in accordance with Part 6 of Subtitle B of Title I of ERISA.

#### **9.19 Compliance with Federal and State Mandates**

It is intended that the Plan meet all applicable requirements of the Code, ERISA, ACA and all other applicable federal and state laws and of all regulations issued thereunder. The Plan must be construed, operated, and administered accordingly. In the event of any conflict between any part, clause, or provision of the Plan and the Code, ERISA, ACA and/or any other applicable federal law, the provisions of the Code, ERISA, ACA and other applicable federal laws are deemed controlling, and any conflicting part, clause, or provision of the Plan is deemed superseded to the extent of the conflict.

#### **9.20 Governing Law**

To the extent not preempted by ERISA or any other federal statutes or regulations, the Plan is governed by and construed, enforced and administered according to the laws of the State of Connecticut.

#### **9.21 Severability**

If any provision of the Plan or the application thereof to any circumstance(s) or person(s) is invalidated by a court of competent jurisdiction, the remainder of the Plan and the application of such provision to other circumstances or persons is not affected thereby.

#### **9.22 Conclusiveness of Records**

The records of the Employer with respect to age, length of service, employment history, compensation, absences, illnesses and all other relevant matters shall be conclusive for

purposes of the administration of, and the resolution of claims arising under, the Component Plans.

### **9.23 Construction**

Whenever used in the Plan, unless the context clearly indicates otherwise, the singular includes the plural and the plural the singular. The conjunction “or” includes both the conjunctive and disjunctive and the adjective “any” means one or more or all. Article, section and other headings have been inserted for convenience of reference only and are to be ignored in any construction of the provisions of the Plan. A reference in the Plan to a “Section” or an “Article” means a Section or Article of the Plan and not of another source unless another source is specified or clearly indicated.



IN WITNESS WHEREOF, this instrument has been executed by the University on the \_\_\_\_ day of \_\_\_\_\_, 2019 and effective as of January 1, 2019.

YALE UNIVERSITY

By:  \_\_\_\_\_

Name: Janet Lindner

Title: Vice President for HR & Admin.

**YALE UNIVERSITY WELFARE AND FRINGE BENEFIT PLAN  
(AMENDED AND RESTATED EFFECTIVE AS OF JANUARY 1, 2019)**

**EXHIBIT A**

**COMPONENT PLANS**

<b>Plan/Program</b>	<b>Funding</b>	<b>Insurer</b>	<b>Incorporated Documents</b>	<b>Benefit</b>	<b>Claims Administrator</b>
Yale Medical Program	General assets (self-funded) Insurance (group accident insurance only provided to Smart Care option Participants)	N/A Colonial Life & Accident Insurance Company	Documents comprising the Summary Plan Descriptions for the Medical Plan options Benefits Booklets for the Yale Medical Program Schedules of Benefits for the Yale Medical Program The Yale Health Plan Members Handbook	Medical/vision Prescription drug Mental health and substance abuse	Aetna Yale University (for the Yale Health Plan option only) Optum Colonial Life & Accident Insurance Company Magellan Health
Yale Dental Program	Insurance	Delta Dental Cigna	Documents comprising the Summary Plan Description for the Yale Dental Program	Dental	Delta Dental Cigna
Yale Vision Program	Insurance	EyeMed Vision Care	Documents comprising the Summary Plan Description for the Yale Vision Program	Vision	EyeMed Vision Care
Yale Health Care Reimbursement Account Program	General assets (self-funded)	N/A	Documents comprising the Summary Plan Description for The Yale Health Care Reimbursement Account Program Yale Flexible Benefits Program for Faculty and Staff Employees	Health flexible spending account (general purpose and limited purpose)	Alight

<b>Plan/Program</b>	<b>Funding</b>	<b>Insurer</b>	<b>Incorporated Documents</b>	<b>Benefit</b>	<b>Claims Administrator</b>
Yale Dependent Care Reimbursement Account Program*	General assets (self-funded)	N/A	Documents describing the Yale Dependent Care Reimbursement Account Program  Yale Flexible Benefits Program for Faculty and Staff Employees	Dependent care flexible spending account	Alight
Yale Non-Contributory Life Insurance Program	Insurance	Standard Life Insurance Company  Hartford Life and Accident Insurance Company	Documents comprising the Summary Plan Description for the Yale Non-Contributory Life Insurance Program	Basic group term life insurance and accident insurance	Standard Life Insurance Company  Hartford Life and Accident Insurance Company
Yale Contributory Life Insurance Program	Insurance	Standard Life Insurance Company	Documents comprising the Summary Plan Description for the Yale Contributory Life Insurance Program	Supplemental group term life insurance and accident insurance	Standard Life Insurance Company
Yale Travel Assistance Program	Insurance	International SOS Global Travel Assistance	Documents describing the Yale Travel Assistance Program	Emergency travel assistance services	International SOS Global Travel Assistance
Yale University Short Term Disability Income Benefit Plan*	General assets (self-funded)	N/A	Documents describing the Yale University Short Term Disability Income Benefit Plan	Disability income	Standard Life Insurance Company
Yale University Voluntary Short Term Disability Income Benefit Plan*	Insurance	Aflac	Documents describing the Yale University Voluntary Short Term Disability Income Benefit Plan	Disability income	Aflac
Yale University Group Long Term Disability Insurance	Insurance	Standard Life Insurance Company	Documents comprising the Summary Plan Description for the Yale University Group Long Term Disability Insurance	Disability income	Standard Life Insurance Company

<b>Plan/Program</b>	<b>Funding</b>	<b>Insurer</b>	<b>Incorporated Documents</b>	<b>Benefit</b>	<b>Claims Administrator</b>
Yale University Group Legal Plan	Insurance	Hyatt Legal Plans, a MetLife Company	Documents comprising the Summary Plan Description for the Yale University Group Legal Plan	Legal assistance	Hyatt Legal Plans, a MetLife Company
Yale University Employee Assistance Program	Insurance	Magellan Health	Documents comprising the Summary Plan Description for the Yale University Employee Assistance Program	Employee assistance benefits	Magellan Health
Yale University Adoption Reimbursement Program*	General assets (self-funded)	N/A	Documents describing the Yale University Adoption Reimbursement Program	Adoption expense reimbursement	Yale University

\*Although included as a Component Plan under the Plan for comprehensiveness and ease of reference, this Component Plan is not an ERISA plan and information about this Component Plan is not included in the Plan's annual Form 5500 filing.

Note: For employee eligibility, contribution, participation, payment and claims information, refer to the Incorporated Documents.