PLAN DOCUMENT
FOR
EMERITI RETIREE HEALTH PLAN
SAINT MARY'S COLLEGE OF CALIFORNIA
(RESTATED JANUARY 1, 2015)

EMERITI®
RETIREMENT HEALTH SOLUTIONS

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PLAN DOCUMENT
EMERITI RETIREE HEALTH MODEL PLAN

ARTICLE I – INTRODUCTION

1.1 Establishment.

The Plan Sponsor adopts the Plan consisting of this Plan Document, the Adoption Agreement, the attached Schedules and Exhibits, and amendments thereto. The name of the Plan shall be the name stated in the Adoption Agreement.

1.2 Effective Date and Plan Year.

The "Effective Date" of the Plan shall be the date set forth in the Adoption Agreement. This restated Plan Document shall be effective as of January 1, 2015, except as otherwise provided herein. The Plan year shall be the calendar year.

1.3 Purpose.

The Plan is primarily intended to provide retiree health benefits to the Employer's former Employees, their Spouses and certain dependents, although other benefits may be provided and other persons may be eligible for benefits, as described herein.

1.4 Administration.

The Plan Sponsor is the "administrator" and "named fiduciary" of the Plan within the meaning of ERISA, except in the event the Plan Sponsor is a Governmental Entity, in which case the Plan Sponsor is responsible for the maintenance, administration and oversight of the Plan in accordance with applicable State law.

ARTICLE II – DEFINITIONS

2.1 Accounts.

The term "Accounts" means, collectively, a Participant's Employee After-Tax Contribution Account and Employer-Contribution Account.

2.2 ACH Transfer.

The term "ACH Transfer" means an automated clearing house transfer or debit of funds from the private account of a Participant or other individual eligible to make such transfers under the Plan for the purposes of (a) making an Employee After-Tax Contribution to the Plan on a one-time or recurring basis subject to Section 3.1, (b) paying Health Insurance Premiums on a recurring monthly basis, in accordance with Section 5.2, and/or (c) paying the reasonable expenses of the Plan in accordance with Section 8.4.

2.3 Authorized Leave of Absence.

The term "Authorized Leave of Absence" means any period of absence from service with the Employer authorized by the Employer under its applicable personnel practices (including any period required by the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended or any period of absence covered by the Family and Medical Leave Act of 1993, as amended). Paid holidays, paid vacation, and regularly scheduled paid or unpaid summer absences are treated separately under the Plan and shall not be included in the term Authorized Leave of Absence.

2.4 Benefits Administrator.

The term "Benefits Administrator" means the service provider(s) providing administrative services under the Plan through the Emeriti Program, including services relating to the administration of Health Insurance Premiums and the payment of Reimbursement Benefits. The Benefits Administrator shall not be a fiduciary of the Plan.

2.5 COBRA.

The term "COBRA" means those provisions of Section 4980B of the Internal Revenue Code, Sections 300bb-1 through 300bb-8 of the Public Health Services Act ("PHSA"), and Sections 601-608 of ERISA pertaining to continuation of health plan coverage.

2.6 Compensation.

The term "Compensation" means W-2 wages unless otherwise defined in the Adoption Agreement.

2.7 Dependent Child.

(a) An individual under the age of 26 shall be considered a "child of the Participant" if:

(1) the individual is the natural child, adopted child, child placed for adoption, or stepchild of the Participant;

(2) the Participant is the permanent legal guardian or permanent custodian of the individual; or

(3) the individual is the natural child, adopted child, or child placed for adoption of the Domestic Partner; provided, however, that with respect to a natural child, adopted child, or child placed for adoption of a Domestic Partner who is not the natural child, adopted child, child placed for adoption, or stepchild of the Participant, such child must: (i) receive over half of his or her support from the Participant; (ii) have as his or her principal place of abode the home of the Participant; and (iii) be a member of the Participant's household.

(b) The term Dependent Child also includes a child of the Participant of any age who meets the requirements of subsection (a) but who is Permanently Disabled.

(c) Designation of Dependent Child. An individual shall not be considered a Dependent Child under the Plan unless so designated by the Participant in accordance with the Record Keeper's reasonable procedures. Although the Record Keeper shall have no obligation to verify the validity of any such designation, the Record Keeper, Health Insurer, or Plan Sponsor may require verification of such designation at any time.

(d) The term "Dependent Children" shall be the plural form of "Dependent Child."

2.8 Dependent Relative.

(a) The term “Dependent Relative” means any of the following individuals who may be claimed as a "dependent" on the Participant's federal tax return in accordance with Section 152 of the Internal Revenue Code (for the relevant plan year), and who has been identified as a Dependent Relative when a claim for Reimbursement Benefits is submitted in accordance with Section 9.3 or after the Participant's death in the accordance with Section 5.7:

(1) a child of the Participant (other than a Dependent Child) or a descendent of a child of the Participant;

(2) a sibling or stepsibling of the Participant;

(3) a parent of the Participant, or an ancestor of a parent;

(4) a stepparent of the Participant;

(5) an aunt, uncle, niece, or nephew of the Participant;

(6) a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law of the Participant; and

(7) any other individual to whom the Participant is related who for the calendar year has as his or her principal place of abode at the home of the Participant and is a member of the Participant's household.

(b) If the Plan Sponsor has not elected to cover Dependent Relatives in the Adoption Agreement, then no individual shall qualify as a Dependent Relative under the Plan.

(c) If an individual is a Dependent Relative at the death of the Participant, such individual shall remain a Dependent Relative so long as any amount remains in the Participant's Account(s).

2.9 Domestic Partner.

(a) The term "Domestic Partner" means an individual who is either a Dependent Domestic Partner or a Non-Dependent Domestic Partner and has been designated as a Dependent or Non-Dependent Domestic Partner during the process of enrolling in Health Insurance Coverage in accordance with Article VI (HEALTH INSURANCE COVERAGE), when a claim for Reimbursement Benefits is submitted in accordance with Section 9.3, or after the Participant's death in accordance with Section 5.7, provided, however, that no individual shall be considered a Dependent or a Non-Dependent Domestic Partner if the Participant has a Spouse or has designated another Domestic Partner.

(b) The term "Dependent Domestic Partner" means an individual of the same or opposite sex as elected by the Plan Sponsor in the Adoption Agreement (other than a relative of the Participant) who for the calendar year

(1) has as his or her principal place of abode the home of the Participant,

(2) is a member of the Participant's household, and

(3) receives over half of his or her support from the Participant such that he or she may be declared as a "dependent" on the Participant's federal tax return in accordance with Section 152 of the Internal Revenue Code.

(c) The term "Non-Dependent Domestic Partner" means an individual of the same or opposite sex as elected by the Plan Sponsor in the Adoption Agreement (other

than a relative of the Participant) who satisfies the requirements of paragraphs (1) and (2), but fails to satisfy paragraph (3) of subsection (b). Benefits received by a Non-Dependent Domestic Partner under the Plan may be subject to federal and state income tax.

(d) The requirements of paragraph (1) of subsections (b) shall continue to be satisfied if the individual resides in an assisted living or medical care facility immediately following a period in which he or she satisfied the remaining applicable requirements of subsections (a), (b) and (c) above.

(e) If the Plan Sponsor has not elected in the Adoption Agreement to cover Domestic Partners, then no individual shall qualify as a Domestic Partner under the Plan, except to the extent required under applicable law.

(f) Notwithstanding any other provision of the Plan, benefits payable to a Domestic Partner with respect to whom distributions would be subject to federal or state income tax may be denied at the direction of the Plan Sponsor if the Participant fails to contribute amounts required to satisfy tax withholding obligations.

2.10 Eligible Employee.

The term "Eligible Employee" means any Employee of the Employer who is not excluded from participation in the Plan in accordance with the Plan Sponsor's election in the Adoption Agreement.

2.11 Emeriti.

The term "Emeriti" means The Emeriti Consortium for Retirement Health Solutions, an Illinois Not-For-Profit Corporation, doing business as Emeriti Retirement Health Solutions and headquartered in New York.

2.12 Emeriti Program.

The term "Emeriti Program" means the collection of documents and services provided by Emeriti, the Benefits Administrator, the Record Keeper, the Health Insurer, and other third parties pursuant to the Membership Contract. The Plan Sponsor participates in the Emeriti Program according to the terms of the Membership Contract.

2.13 Employee.

The term "Employee" means any person classified by the Employer as a common law employee of the Employer, but excluding: (i) any person classified as an independent contractor (regardless of whether such classification is determined to be correct as a matter of law); (ii) a leased employee as defined under Section 414(n) of the Internal Revenue Code (regardless of whether such classification is determined to be correct as a

matter of law); and (iii) any individual who is providing services on a temporary basis or designated to work only with respect to specific tasks or projects.

2.14 Employee After-Tax Contributions.

The term "Employee After-Tax Contributions" means after-tax contributions to a Participant's Employee After-Tax Contribution Account made in accordance with Section 3.1 of the Plan.

2.15 Employee After-Tax Contribution Account.

The term "Employee After-Tax Contribution Account" means the account maintained for each Participant showing the aggregate value of the Employee After-Tax Contributions made by such Participant after adjustment for changes in market valuation, gains and losses, expenses, distributions, or forfeitures, if any, or, alternatively, the same contributions identified by source code within a single account reflecting both Employee-After-Tax Contributions and Employer Contributions.

2.16 Employee After-Tax Contribution Trust.

The term "Employee After-Tax Contribution Trust" means the trust established by the Plan Sponsor to receive and hold Employee After-Tax Contributions under the Plan. The Employee After-Tax Contribution Trust is intended to qualify as a voluntary employees' beneficiary association ("VEBA") under Section 501(c)(9) of the Internal Revenue Code. If the Plan Sponsor is a Governmental Entity, the term "Employee After-Tax Contribution Trust" means either a trust intended to qualify as a VEBA or a trust intended to satisfy the requirements of Section 115 of the Internal Revenue Code, as determined by the Plan Sponsor's election in the Adoption Agreement and the terms of the Trust Agreement.

2.17 Employer.

The term "Employer" means the Plan Sponsor and each Participating Affiliate.

2.18 Employer Contributions.

The term "Employer Contributions" means contributions to a Participant's Employer-Contribution Account made in accordance with Section 3.2 of the Plan.

2.19 Employer-Contribution Account.

The term "Employer-Contribution Account" means the account maintained for each Participant showing the aggregate value of the Employer Contributions allocated to such account after adjustment for changes in market valuation, gains and losses, expenses, distributions, or forfeitures, if any, or, alternatively, the same contributions identified by

source code within a single account reflecting both Employee-After-Tax Contributions and Employer Contributions.

2.20 Employer-Contribution Trust.

The term "Employer-Contribution Trust" means the trust established by the Plan Sponsor to receive and hold Employer Contributions under the Plan. The Employer-Contribution Trust is intended to qualify as a voluntary employees' beneficiary association ("VEBA") under Section 501(c)(9) of the Internal Revenue Code. If the Plan Sponsor is a Governmental Entity, the term "Employer-Contribution Trust" means either a trust intended to qualify as a VEBA or a trust intended to satisfy the requirements of Section 115 of the Internal Revenue Code, as determined by the Plan Sponsor's election in the Adoption Agreement and the terms of the Trust Agreement.

2.21 ERISA.

The term "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

2.22 Governmental Entity.

The term "Governmental Entity" means a "governmental entity" subject to Section 115 of the Internal Revenue Code.

2.23 Health Insurance Benefits.

The term "Health Insurance Benefits" means those benefits provided to a Participant, Spouse (or Domestic Partner), and/or Dependent Child, in accordance with Article VI (HEALTH INSURANCE COVERAGE) under any Health Insurance Plan Option in which such person is enrolled.

2.24 Health Insurance Coverage.

The term "Health Insurance Coverage" means coverage under the group health insurance policy (or policies) issued by the Health Insurer(s) and made available to the Plan Sponsor through the Emeriti Program for eligible Participants, their Spouses (or Domestic Partners), and Dependent Children. The terms of the insurance policy (or policies) may change periodically.

2.25 Health Insurance Plan Option.

(a) The term "Health Insurance Plan Option" means either a Post-65 Health Insurance Plan Option as defined in subsection (b) or a Pre-65 Health Insurance Plan Option as defined in subsection (c). The terms of eligibility and coverage for any Health Insurance Plan Option shall be those described in the group health insurance policy (including any certificates of coverage and similar

documentation) issued by the Health Insurer(s). The Health Insurance Plan Options may vary from state to state and territory to territory (and may not be available in all jurisdictions).

(b) The term "Post-65 Health Insurance Plan Option" means an insurance plan that is either integrated with Medicare Parts A and B or offered under Medicare Parts C or D and provided under the Plan to eligible Participants, their Spouses (and Domestic Partners), and persons who are Permanently Disabled.

(c) The term "Pre-65 Health Insurance Plan Option" means an insurance plan that may include both medical and prescription drug benefits for eligible Participants who retire prior to Medicare eligibility, Spouses (and Domestic Partners) who are not yet eligible for Medicare, and Dependent Children.

(d) Dependent Relatives shall not be eligible for any Post-65 or Pre-65 Health Insurance Plan Option.

(e) Health Insurance Plan Options, including options providing non-major medical coverage (such as dental and vision insurances), may be added to or eliminated from the Emeriti Program and the Plan without amendment to the Plan. The Health Insurance Plan Options available under the Plan may vary on a state-by-state basis (and may not be available in certain states) and may vary from time to time.

(f) Notwithstanding anything herein to the contrary, enrollment in and coverage under each Health Insurance Plan Option is subject to the requirements of any applicable State or Federal laws, regulations, or regulatory guidance. Each Post-65 Health Insurance Plan Option is subject to the requirements of Medicare and any other applicable State or Federal laws, regulations, or regulatory guidance.

2.26 Health Insurance Premiums.

The term “Health Insurance Premiums” means premiums for Health Insurance Coverage, which may include any penalties assessed by the Centers for Medicare and Medicaid Services for late enrollment in Medicare.

2.27 Health Insurer.

The term “Health Insurer” means the health insurance issuer or issuers selected by Emeriti to provide Health Insurance Benefits under the Plan through the Emeriti Program.

2.28 Internal Revenue Code.

The term “Internal Revenue Code” means the Internal Revenue Code of 1986, as amended, or any subsequently enacted Federal revenue law. A reference to a particular

Internal Revenue Code section shall be deemed to include a reference to any regulations issued under that section and to the corresponding section of any subsequently enacted Federal law.

2.29 Investment Options.

The term "Investment Options" means the mutual funds and other investment funds selected in accordance with Section 4.1.

2.30 Medicare.

The term "Medicare" means Health Insurance for the Aged and Disabled under Title XVIII of the Social Security Act, as amended from time to time. If a particular part of Medicare applies (e.g., Medicare Part A, Part B, Part C, or Part D), it is noted in the relevant provision.

2.31 Membership Contract.

The term "Membership Contract" means the contract entered into between the Plan Sponsor and Emeriti prior to, or coincident with, the adoption of the Plan, which establishes the Plan Sponsor's participation in the Emeriti Program and obligations in connection therewith, and which may be amended from time to time. Upon termination of the Membership Contract, the Plan Sponsor's participation in the Emeriti Program ceases.

2.32 Other Health Insurance.

The term "Other Health Insurance" means health insurance obtained by a Participant, Spouse (or Domestic Partner), Dependent Child, and/or Dependent Relative outside of the Emeriti Program. The premiums for Other Health Insurance may be reimbursed from the Participant's Accounts in accordance with Article VII (REIMBURSEMENT BENEFITS). The term "Other Health Insurance" includes COBRA continuation coverage (or the College's Health Insurance Continuation Plan (HICuP)), but excludes coverage for any individual as an active employee (or as a spouse, domestic partner or dependent of an active employee) under an employer-sponsored group health plan.

2.33 Participant.

The term "Participant" means any of the following persons:

(a) a current or former Eligible Employee for whom an Employee After-Tax Contribution Account and/or an Employer-Contribution Account is maintained under the Plan;

(b) a former Eligible Employee who is eligible for, or enrolled in, Health Insurance Coverage;

(c) a former Employee who retired on or before the Effective Date of the Plan and (i) who is permitted and elects to participate in Health Insurance Coverage, or (ii) for whom an Employee After-Tax Contribution Account and/or Employer-Contribution Account is established under the Plan.

2.34 Participating Affiliate.

The term "Participating Affiliate" means each Internal Revenue Code Section 501(c)(3) tax-exempt organization that is under "common control" with the Plan Sponsor (as determined by the Plan Sponsor in accordance with Section 414(c) of the Internal Revenue Code and any applicable Internal Revenue Service guidance thereunder) and that is identified in the Adoption Agreement. In the case of a Plan Sponsor that is a Governmental Entity funding the Plan with Section 115 trusts, "Participating Affiliate" means each affiliated entity identified in the Adoption Agreement that is a "Governmental Entity." In the case of a Plan Sponsor that is a Governmental Entity funding the Plan with VEBA trusts, "Participating Affiliate" means each affiliated entity identified in the Adoption Agreement that either is exempt under Internal Revenue Code Section 501(c)(3) or is a "Governmental Entity."

2.35 Payroll Period.

The term "Payroll Period" means the period for which the Participant is directly or indirectly paid or entitled to payment by the Employer for the performance of services as an Employee.

2.36 Permanently Disabled.

(a) With respect to the following persons, the term "Permanently Disabled" means having received a final determination letter from the Social Security Administration stating that such person is permanently disabled and establishing an onset date prior to termination of employment:

(1) a Participant who is a current or former Eligible Employee and who became permanently disabled no later than the date of his or her termination of employment with the Employer;

(2) the Spouse, Domestic Partner, or Dependent Child of a Participant who became permanently disabled when the Participant was enrolled in Pre-65 or Post-65 Health Insurance Plan Option.

(b) A Dependent Relative shall not be eligible to be considered Permanently Disabled under the Plan.

(c) A determination by the Social Security Administration shall be final with respect to the Plan and shall not be subject to review by the Plan Sponsor, the Health

Insurer, or Emeriti (other than for the Plan Sponsor or Health Insurer to verify that such determination has issued).

2.37 Plan.

The term "Plan" means the employee welfare benefit plan set forth in this Plan Document and the Adoption Agreement, the name of which is designated in the Adoption Agreement. The terms of this Plan Document shall be interpreted in accordance with the elections made by the Plan Sponsor in the Adoption Agreement. (The term "Adoption Agreement" shall include all Schedules appended to it.)

2.38 Plan Sponsor.

The term "Plan Sponsor" means the organization identified in the Adoption Agreement and in the Membership Contract as the "Member Organization." The Plan Sponsor shall be either an Internal Revenue Code Section 501(c)(3) tax-exempt organization or a Governmental Entity satisfying Section 115 of the Internal Revenue Code Section.

2.39 Qualified Medical Expenses.

The term "Qualified Medical Expenses" means those expenses incurred, on or after the date the Participant becomes eligible for Reimbursement Benefits, by the Participant, Spouse (or Domestic Partner), Dependent Children, and Dependent Relatives (to the extent such individuals are covered pursuant to the Adoption Agreement) for "medical care" as defined in Section 213(d) of the Internal Revenue Code, but only to the extent such amounts are not compensated for by insurance or otherwise. For purposes of this Plan, an expense is "incurred" when the medical care or services giving rise to the claimed expense are furnished. In the case of premiums for Other Health Insurance, an expense is "incurred" when the premiums are due for issued coverage or, if earlier, at the onset of the coverage period. Claims for the reimbursement of Qualified Medical Expenses shall be processed in accordance with Section 9.3.

2.40 Record Keeper.

The term "Record Keeper" means the service provider(s) selected by Emeriti to provide recordkeeping, investment, and administrative services under the Plan through the Emeriti Program. The Record Keeper shall not be a fiduciary of the Plan, except to the extent it performs any fiduciary functions within the scope of its authority with respect to the Plan.

2.41 Reimbursement Benefits.

The term "Reimbursement Benefits" means the reimbursement of Qualified Medical Expenses from the Employee After-Tax Contribution Trust and the Employer-Contribution Trust, value of which shall not exceed the balances recorded in a

Participant’s Accounts in accordance with Article VII (REIMBURSEMENT BENEFITS).

2.42 Retirement Eligibility.

The term “Retirement Eligibility” means the age and service (Years of Continuous Service) criteria designated by the Plan Sponsor in the Adoption Agreement for the purpose of determining a Participant's eligibility for Health Insurance Benefits.

2.43 Spouse.

The term “Spouse” means the person to whom a Participant is legally married (or was legally married upon his or her death), excluding a common law spouse, and who is designated or identified as the Spouse during the process of enrolling in Health Insurance Coverage in accordance with Article VI (HEALTH INSURANCE COVERAGE), when a claim for Reimbursement Benefits is submitted in accordance with Section 9.3, or after the Participant's death in accordance with Section 5.7.

2.44 Trust Agreements.

The term “Trust Agreements” means the trust instruments for the Employee After-Tax Contribution Trust and the Employer-Contribution Trust entered into to create the Employee After-Tax Contribution Trust and the Employer-Contribution Trust.

2.45 Trustee.

The term “Trustee” means the trustee selected under the terms of the Plan and Trust(s).

2.46 Trusts.

The term “Trusts” means, collectively, the Employee After-Tax Contribution Trust and the Employer-Contribution Trust established under the Trust Agreements.

2.47 Year of Continuous Service.

The term “Year of Continuous Service” means each twelve (12)-month period of employment with the Employer as determined by the Plan Sponsor based on the terms elected in the Adoption Agreement and subject to the following:

(a) Years of Continuous Service shall include any service required to be credited under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, whenever the Plan Sponsor provides such service credit for comparable non-military unpaid leaves of absence not based on seniority.

(b) If a Participant who has ceased working for the Employer returns to service prior to incurring a one-year Break in Service, such Participant’s prior service shall be included in the Participant’s Years of Continuous Service.

(c) If a Participant who has incurred a Break in Service returns to service after incurring a one-year Break in Service, such Participant’s prior service shall not be included in the Participant’s Years of Continuous Service when determining his or her Retirement Eligibility and/or his or her eligibility for Reimbursement Benefits (drawn from the Participant's Employer-Contribution Account) unless he or she had already satisfied the applicable requirements set forth in the Adoption Agreement when the Break in Service commenced.

(d) The term “Break in Service” shall mean any period of absence from active service with the Employer that is not an Authorized Leave of Absence, paid holiday, paid vacation, or regularly scheduled paid or unpaid summer absence, or a period required to be credited in accordance with subsection (a).

ARTICLE III – ESTABLISHMENT OF ACCOUNTS AND CONTRIBUTIONS

3.1 Employee After-Tax Contributions.

(a) Establishment of Employee After-Tax Contribution Account. If the Plan Sponsor elects in the Adoption Agreement to permit Eligible Employees to make contributions to the Plan, the Employer shall instruct the Record Keeper to establish an Employee After-Tax Contribution Account for the following persons upon their becoming eligible to make Employee After-Tax Contributions:

(1) each Eligible Employee who is permitted to make Employee After-Tax Contributions under the terms of the Adoption Agreement; and

(2) each retired Employee referred to in Section 2.33(c).

(b) After-Tax Payroll Deductions.

(1) Commencement. An Eligible Employee may make an election to contribute to his or her Employee After-Tax Contribution Account by payroll deduction in accordance with procedures established by the Employer and the Record Keeper. The Employer shall commence after-tax payroll deductions as soon as administratively feasible after the Eligible Employee elects to make contributions.

(2) Amount and Frequency of Employee After-Tax Contribution and Duration of Election. The Eligible Employee shall elect the amount of after-tax contributions to be deducted from his or her pay, subject to the Plan Sponsor's election in the Adoption Agreement pertaining to the permissible form, amount and frequency of contribution. The election shall be treated as a standing election during the period of his or her employment with the Employer until severance of employment, or, if earlier, until the Eligible Employee makes a new election. He or she may elect to change the amount at any time, and such election shall be effective as soon as administratively feasible.

(3) Automatic Contributions. If the Plan Sponsor elects to establish an automatic contribution provision in the Adoption Agreement, an Eligible Employee (or an individual who is in a specified class of Eligible Employees described in the Adoption Agreement) shall be treated as having elected to make Employee After-Tax Contributions in the amount set forth in the Adoption Agreement on a payroll basis until such Eligible Employee specifically elects not to have such contributions made (or specifically elects to have such contributions made in a different amount). If the Employer establishes an automatic contribution provision, the Plan shall provide notice to Eligible Employees in a manner consistent with the regulations promulgated under Section 414(w)(4) of the Internal Revenue

Code, except in no case shall the Plan permit an employee who has had a contribution made under this subsection to withdraw such contribution.

(4) Remittance of Employee After-Tax Contributions. The Employer shall remit Employee After-Tax Contributions made by after-tax payroll deductions to the Trustee as of the earliest date on which they can reasonably be segregated from the Employer's general assets, but in no event later than the date prescribed by the Department of Labor under 29 C.F.R. 2510.3-102.

(c) Employee After-Tax Contributions Made By Other Means. If the Plan Sponsor elects to permit Employee After-Tax Contributions to the Plan, the following Participants may make Employee After-Tax Contributions by ACH Transfer or by such other forms of payment permitted by the Record Keeper:

(1) a Participant who is actively employed with the Employer;

(2) a Participant who has ceased employment with the Employer with any nonforfeitable balance in his or her Employee After-Tax Contribution Account or Employer Contribution Account;

(3) a Participant who has ceased employment with the Employer after meeting the criteria for Retirement Eligibility, irrespective of whether he or she has a balance in his or her Accounts;

(4) a Participant who has ceased employment with the Employer as a result of becoming Permanently Disabled; and

(5) a Participant who is a retired Employee described in Section 2.33(c).

If a Participant described in paragraph (c)(2) of this Section 3.1 has not previously created an Employee After-Tax Contribution Account, one will be created upon receipt of payment from the Participant.

3.2 Employer Contributions.

(a) Establishment of Employer Contribution Account. If the Plan Sponsor elects in the Adoption Agreement to make contributions to the Plan on behalf of each Eligible Employee who satisfies the requirements set forth in the Adoption Agreement, the Employer shall instruct the Record Keeper to establish an Employer Contribution Account for each Eligible Employee when such contributions commence.

(b) Employer Contributions.

(1) Commencement. The Employer shall make contributions to the Employer Contribution Account of each Eligible Employee when he or she first becomes eligible for Employer Contributions in accordance with the provisions of the Adoption Agreement beginning with the first Payroll Period in the first month following such date.

(2) Amount

(i) The “annual contribution”, which shall be determined at the discretion of the Plan Sponsor in accordance with the requirements of the Emeriti Program and set forth in the Adoption Agreement, shall be equal to, or greater than, one-half of one percent (0.5%) of the annual payroll for all Participants who are Eligible Employees, or as otherwise agreed between Emeriti and the Plan Sponsor.

(ii) The "annual contribution" may be temporarily reduced or suspended during periods of financial exigency, for a period of no more than [three (3)] consecutive "annual contribution" periods, provided the Plan Sponsor and Emeriti agree to the reduction or suspension, or may be reduced or suspended for a different period, as otherwise agreed between the Plan Sponsor and Emeriti. Such reduction or suspension shall be implemented by an amendment to the Adoption Agreement.

(iii) The Employer Contribution may be a matching contribution contingent on an Eligible Employee making an Employee After-Tax Contribution subject to the contribution satisfying the applicable nondiscrimination rules promulgated under the tax code. Matching contributions will be subject to such conditions and administrative rules as may be established by Emeriti.

(3) Credited Service. Subject to the Plan Sponsor’s election in the Adoption Agreement to credit service on an alternative basis and/or to make matching contributions, the Employer shall make regularly scheduled Employer Contributions to a Participant’s Employer-Contribution Account for the following periods of service:

(i) each Payroll Period during which the Participant performs at least one hour of service for which he or she is directly or indirectly paid or entitled to payment by the Employer as an Employee, subject to the Plan Sponsor's election in the Adoption Agreement to credit service on an alternative basis,

(ii) any Payroll Period during which the Participant is on an unpaid Authorized Leave of Absence, if the Plan Sponsor has made an election to do so in the Adoption Agreement,

(iii) any Payroll Period during which the Participant is on a paid Authorized Leave of Absence, paid holiday, paid vacation, or regularly scheduled paid or unpaid summer absence, and

(iv) any period for which contributions are required to be made under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and the Family and Medical Leave Act of 1993, as amended, regardless of any Plan Sponsor election in the Adoption Agreement to the contrary.

(4) Frequency of Contribution. The Employer shall make its contributions at a frequency established in the Adoption Agreement, but no less than annually.

(5) Duration of Employer Contributions. Unless otherwise specified in the Adoption Agreement, the Employer shall cease making Employer Contributions on behalf of a Participant following his or her termination of employment with the Employer, or, if earlier, after his or her attaining the maximum number of years of credited service/participation identified in the Adoption Agreement. The Employer shall inform the Record Keeper of a change in a Participant's employment status or his or her attaining the maximum years of service.

(c) Transition Rule—Special Employer Contribution(s) at Plan Inception.

(1) Provided the contribution does not violate Internal Revenue Code Section 501(c)(9) or any other applicable provision of the Internal Revenue Code, the Employer may make one or more of the following, special transition Employer Contributions (contributed in a lump sum or installments) to each person in one or both of the classes:

(i) the class of current Eligible Employees for whom the Employer is otherwise required to commence making Employer Contributions beginning on the Effective Date of the Plan, or a defined group of Employees within such class;

(ii) a class of former Employees who, upon the Effective Date, are receiving (or are entitled to receive) retiree medical benefits from the Employer under an existing retiree medical plan of the Employer and/or former Employees who are not receiving such benefits.

(2) The amount (or formula for determining such amount) of any special transition Employer Contributions, and the class(es) of Eligible and/or former Employees to whom it applies, shall be described in the Adoption Agreement (subject to the requirements set forth in the Adoption Agreement regarding minimum contributions) and shall be based upon one or more of the following:

(i) a flat dollar amount as determined by the Employer;

(ii) an amount equal to the total amount of Employer Contributions the individual would have received had the Plan been in effect during the individual's entire period of employment with the Employer, limited to a maximum number of look-back years if so determined by the Employer;

(iii) an amount reflecting all or a portion of the value of a retiree health benefit being replaced by benefits under this Plan; or

(iv) an amount determined on any other basis that satisfies all applicable nondiscrimination requirements.

(d) Additional Conditions. Employer Contributions shall be subject to any additional conditions established by the Plan Sponsor in the Adoption Agreement.

ARTICLE IV – INVESTMENT OF ACCOUNTS

4.1 Investment Options.

The Investment Options available under the Plan shall be solely those designated in writing to the Record Keeper from time to time by the Plan Sponsor, subject to the limitation that during the term of the Membership Contract the Plan Sponsor may select only from the menu of Investment Options made available from time to time under the Emeriti Program.

4.2 Investment of Accounts.

The named fiduciary, as identified in the Trust Agreement(s), shall be responsible for directing the investment of the assets of the Plan held in the Trust(s) and shall direct the Trustee to accept direction from each Participant with respect to the balances in each Participant's Accounts. The balance in the Accounts shall be invested in the Investment Options in accordance with the Participant's direction consistent with any limitations set forth in the Trust Agreement(s) and subject to the following:

(a) Investment Election for Contributions. A Participant shall file an investment election with the Record Keeper directing that contributions made to each Account shall be invested in any one or more of the Mutual Funds, subject to reasonable restrictions established by the Record Keeper or the investment manager of the Mutual Fund in its prospectus. A Participant may elect to change the investment of future contributions by filing a new investment election with the Record Keeper.

(b) Default Investments. In the absence of an effective election with respect to an Account, all contributions to such Account shall be invested in the Mutual Fund designated by the Plan Sponsor for such purpose, as set forth in the Trust Agreement(s). A Participant may elect to change the investment by making an election for future contributions under subsection (a) and/or transferring existing balances under subsection (c).

(c) Transfer of Existing Balance. A Participant, by notifying the Record Keeper, may elect to change the investment of the balance of his or her Account(s) (i.e., transfer all or a portion of the balance from one Mutual Fund to another) in an amount not less than the minimum amount prescribed by the Record Keeper.

(d) Limitations on Investment Elections. Notwithstanding, the foregoing subsections (a), (b) and (c), the named fiduciary (or in the case of a plan established by a Governmental Entity, the Plan Sponsor), may:

(1) impose upon any Mutual Fund such restrictions as Emeriti deems necessary or appropriate for plans established under the Emeriti Program, including, but not limited to, restrictions on frequency and amount of

transfers to or from a Mutual Fund, provided the Record Keeper is able to administratively implement such restrictions, and the restrictions are not inconsistent with the prospectus for the Mutual Fund; and

(2) require the Participant to invest all or a portion of an Account balance in a money market or similar cash-equivalent investment and/or require the Participant to direct the Trustee to transfer all or a portion of an Account balance to a disbursement account to facilitate the payment of Plan expenses, the payment of Health Insurance Premiums and the disbursement of benefits.

(e) Investment of Forfeiture Accounts. The Plan Sponsor shall be responsible for directing the investment of the Employee After-Tax Contribution Trust's forfeiture account and the Employer-Contribution Trust's forfeiture account established in accordance with Section 5.9. Unless otherwise directed by the Plan Sponsor, the Employee After-Tax Contribution Trust's forfeiture account and the Employer-Contribution Trust's forfeiture account shall be invested in a money market or similar fund that is a Mutual Fund.

4.3 Transaction Confirmations, Account Statements, Prospectuses and Related Documents.

(a) Transaction Confirmations. Subject to requirements imposed under applicable Federal law, the Record Keeper shall distribute transaction confirmations to Participants following a transaction. If a transaction is initiated over the internet, the Record Keeper shall provide the Participant with a choice between paper (by mail) or electronic confirmation. If a transaction is initiated by telephone, the Record Keeper shall deliver a paper confirmation by mail, or at the election of the Participant, electronic confirmation.

(b) Account Statements. The Record Keeper shall deliver to each Participant a statement of the balances in his or her Accounts no less than once each year.

(c) Prospectus Materials and Mutual Fund Reports. . The Record Keeper shall provide each Participant with the following:

(i) a copy of the prospectus for a Mutual Fund when he or she first allocates a portion of his or her Account(s) to such Mutual Fund, unless the Participant has received a copy during the 30 days prior to the allocation and the Participant has informed the Record Keeper that he or she previously received the prospectus, and

(ii) supplements, updates, semi-annual reports, annual reports for each Mutual Fund in which the Participant has allocated a portion of his or her Account(s), proxy statements, and any other information

that he or she would have received if he or she were the mutual fund shareholder of record.

(d) Electronic delivery and access.

(1) The Record Keeper shall deliver account statements, prospectuses and documents described in subsection (c)(ii) on paper and by mail, unless the Participant elects to receive electronic versions of these documents.

(2) The Record Keeper shall provide Participants with access to phone representatives, an automated phone system, and a website through which they can access current Account information and current versions of the documents described in this Section 4.3.

4.4 Effect of Participant's Death.

In the event a Participant dies, Sections 4.2 and 4.3 shall apply to the individual controlling the Account(s) in accordance with Section 5.7 in lieu of the Participant.

ARTICLE V – USE OF ACCOUNTS

5.1 Use of Accounts.

Subject to the forfeiture provisions of this Article V, the balances in a Participant's Accounts shall be used solely to pay the following:

(a) Health Insurance Premiums for Health Insurance Coverage, subject to the Participant's satisfying the Retirement Eligibility requirements established in the Adoption Agreement, the requirements set forth in Article VI (HEALTH INSURANCE COVERAGE) and the procedures set forth in Section 9.1 of Article IX (CLAIMS PROCEDURES),

(b) Reimbursement Benefits, subject to the eligibility requirements established in the Adoption Agreement, the requirements and limitations set forth in Article VII (REIMBURSEMENT BENEFITS), and the procedures set forth in Section 9.3 of Article IX (CLAIMS PROCEDURES),

(c) Participant-level fees (including when the Participant is an active Employee), provided such fees are not paid by the Plan Sponsor, as set forth in the Adoption Agreement, and

(d) Plan expenses according to Section 8.4 of Article VIII.

5.2 Payment of Health Insurance Premiums from Accounts.

(a) Health Insurance Premiums paid by the Plan on behalf of a Participant shall be deducted from the balance in the Participant's Employer-Contribution Account and, if an insufficient balance remains in that account, then from the Participant's Employee After-Tax Contribution Account.

(b) If there is an insufficient balance in both Accounts, the Participant, Spouse (or Domestic Partner), or Dependent Child, as applicable, shall pay Health Insurance Premiums solely by ACH Transfer, unless a partial payment from each source is permitted, in accordance with reasonable administrative procedures that may be established.

5.3 Payment of Reimbursement Benefits.

Reimbursement Benefits paid by the Plan to a Participant shall be deducted from the balance in the Participant's Employee After-Tax Contribution Account and, if an insufficient balance remains in that account, then from the Participant's Employer Contribution Account.

5.4 Exhaustion of Accounts.

If the balance of both Accounts reaches zero dollars ($0) and neither the Participant (as permitted under Section 3.1) nor the Employer (as may be required under Section 3.2 and the terms of the Adoption Agreement) make additional contributions, then Health Insurance Premiums and Participant-level fees shall be paid solely by ACH Transfer, and Reimbursement Benefits shall no longer be paid.

5.5 Coordination of Payment from Multiple Plans Under the Emeriti Program.

In the case of any Participant who participates in this Plan and one or more plans of one or more other plan sponsors under the Emeriti Program (an "Emeriti Plan"), the following rules shall apply, unless otherwise determined by Emeriti:

(a) Health Insurance Premiums and Reimbursement Benefits shall be paid first from the Emeriti Plan in which the Participant (or other covered individual) first elects to commence the payment of benefits.

(b) Upon exhaustion of the Participant's Accounts in the plan elected in subsection (a), payments of Health Insurance Premiums and Reimbursement Benefits shall be made next from the Emeriti Plan in which the Participant most recently had an Account established ("another Emeriti Plan"), and so on.

(c) A Participant described in subsection (b) shall retain Health Insurance Coverage under the Plan in which he or she first enrolled and shall not be permitted or required to re-enroll in Health Insurance Coverage under another Emeriti Plan.

(d) The provisions of the Emeriti Plan under which the Participant (or other individual) had first elected Health Insurance Coverage or received Reimbursement Benefits shall continue to apply, without regard to the provisions of another Emeriti Plan from which Health Insurance Premiums and Reimbursement Benefits are being paid.

5.6 Inactive Accounts.

If the Participant's Accounts remain inactive for a period of three (3) consecutive years at any time following the earlier of: (a) the Participant's death or (b) the later of the date the Participant attains age sixty five (65) or retires, then the Plan Sponsor may, in its sole discretion, take action to locate the Participant or any person who may be eligible for benefits under the Plan, subject to any intervening obligations that the Record Keeper, Benefits Administrator, Trustee, or Health Insurer may have under the terms of their contractual agreements with Emeriti or the Plan Sponsor, or under applicable law. If the Plan Sponsor is unable to locate the Participant (or confirm that the Participant is deceased), the Plan Sponsor may instruct the Record Keeper and Trustee to forfeit the balance of the Participant's Accounts in accordance with this Article V. In the event that the Participant is deceased, the Spouse (or Domestic Partner) may be contacted. In the

event that there is no Spouse (or Domestic Partner) or such individual is also deceased, each Dependent Child and Dependent Relative may be contacted in order to identify the person responsible for controlling the use of the Accounts under Section 5.7.

In the event that the Participant or other individual with rights to the Accounts contacts the Plan Sponsor, Record Keeper, or Benefits Administrator after a forfeiture, the forfeiture shall be subject to reinstatement (including applicable gains and losses calculated in accordance with reasonable administrative procedures that may be established) paid out of each Trust's forfeiture account (or by the Plan Sponsor if such forfeiture accounts are insufficient).

5.7 Control of Accounts and Effect of Participant's Death.

(a) The Participant shall control the investment of the balance in his or her Account(s) and the use of the Accounts in accordance with Article IV (INVESTMENT OF ACCOUNTS) and Article V (USE OF ACCOUNTS).

(b) If the Participant dies and a balance remains in his or her Account(s), then the Accounts shall be controlled by his or her Spouse (or Domestic Partner). If there is no surviving Spouse (or Domestic Partner) or such person dies or opts out of exercising control, then, unless otherwise elected by the Participant prior to his or her death, the following person shall control the Account(s): the oldest Dependent Child (or his or her legal guardian or permanent custodian) until he or she ceases to be a Dependent Child, dies, or opts out, and then the next Dependent Child as ranked by age (or his or her legal guardian or permanent custodian) until he or she ceases to be Dependent Child, dies, or opts out, and so on. If there are no remaining Dependent Children (or the last such individual has opted out), then the oldest Dependent Relative shall control the Accounts, unless he or she elects to opt out (provided, however, that the last such individual may not elect to opt out).

(c) An individual who was not designated as a Spouse, Domestic Partner, Dependent Child or Dependent Relative prior to the Participant's death shall be treated as a Spouse, Domestic Partner, Dependent Child or Dependent Relative if the individual, his or her legal guardian or permanent custodian, or the person identified in subsection (b) shows valid evidence that the individual would have qualified as such on the date of the Participant's death had the Participant properly designated such individual as his or her Spouse, Domestic Partner, Dependent Child, or Dependent Relative. The evidence must be submitted within one hundred and eighty (180) days following the date of the Participant's death, subject to reasonable procedures that may be established.

5.8 Forfeitures.

(a) If a Participant has severed service with the Employer and has not satisfied the requirements established in the Adoption Agreement to avoid forfeiture of Employer Contributions upon termination of employment, the forfeitable balance

in the Employer Contribution Account shall be forfeited at the direction of the Plan Sponsor, subject to the Plan's Break-in-Service provisions.

(b) 1. Notwithstanding subsection (a), if a Participant becomes Permanently Disabled while employed by the Employer, the balances in his or her Employer-Contribution Account shall not be subject to forfeiture unless the Participant is unable to satisfy the conditions described in this paragraph. If the Participant is not able to establish that he or she is Permanently Disabled upon termination of employment, his or her Employer-Contribution Account shall be forfeited as described in subsection (a), provided, however, that the Employer shall restore the amount forfeited to the Participant's Employer-Contribution Account (following the procedure established for inactive accounts established under Section 5.6) if the Participant establishes that he or she is Permanently Disabled before the first to occur of the following:

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(i) Thirty-six (36) months following receipt by the Plan Sponsor of written certification from the Participant or a person authorized to act for the Participant that an application for permanent disability benefits has been filed by or for the Participant with the Social Security Administration with an alleged onset date prior to the date of termination, provided that a copy of the application is received by the Plan Sponsor within twelve (12) months of the date of termination of employment and a copy of the award is received by the Plan Sponsor within the thirty-six-month (36-month) period; or

(ii) In absence of receipt of the notice and award described in the previous subparagraph, twelve (12) months of the date of termination of employment.

2. Notwithstanding subsection (a), if a Participant meets the criteria relating to terminal illness or injury (Section 7.3) or catastrophic medical expenses (Section 7.4) while employed or within twelve (12) months of termination of employment, the balances in his or her Employer-Contribution Account shall not be subject to forfeiture to the extent described in those sections, respectively. If the Participant is not able to establish that he or she meets the criteria relating to terminal illness or injury or catastrophic medical expenses upon termination of employment or within twelve (12) months thereafter, his or her Employer-Contribution Account shall be forfeited as described in subsection (a).

(c) If the Participant ceases to be employed by the Employer due to death, the portion of the balance of the Participant's Employer-Contribution Account that is subject to forfeiture shall be forfeited in accordance with subsection (a).

(d) If any residual balance remains in a Participant's Employee After-Tax Contribution Account and/or Employer-Contribution Account on the date that all of the following have occurred: (A) the Participant has died; (B) the Spouse (or

Domestic Partner) has died; (C) all Dependent Children have died or reached majority; (D) all Dependent Relatives have died; and (E) all pending claims have been paid, then no additional benefits shall be paid under the Plan from such Accounts, and the Plan Sponsor shall instruct the Record Keeper to forfeit the entire residual balance of the Participant's Accounts as soon as administratively feasible.

5.9 Establishment and Use of Forfeiture Accounts.

(a) Establishment of Forfeiture Accounts. The Plan Sponsor shall direct the Trustee to establish a forfeiture account for forfeitures in the Employer-Contribution Trust and a similar account in the Employee After-Tax Contribution Trust, or, alternatively, a single account in which the forfeited contributions are identified by source code reflecting both Employer Contributions and Employee After-Tax Contributions.

(b) Use of the Employer Contribution Trust's Forfeiture Account. Forfeitures in the Employer-Contribution Trust's forfeiture account shall be treated in accordance with the Plan Sponsor's election in the Adoption Agreement; provided, however, that the Plan Sponsor may change its election regarding the treatment of the forfeitures each Plan Year by providing the Record Keeper with notice in accordance with its reasonable procedures. If the Plan Sponsor elects that forfeitures are to be allocated to remaining Participants in the Plan (in addition to the Employer's contribution obligation under the Plan), then the Plan Sponsor shall instruct the Record Keeper that all or a portion of the balance of the forfeiture account is to be allocated on an equal (per Participant, flat-dollar) basis to the Employer-Contribution Accounts of all Participants who, on the date of such allocation, have a positive balance in their Employer-Contribution Accounts.

(c) Use of the Employee After-Tax Contribution Trust's Forfeiture Account. Except as otherwise specified in the Adoption Agreement, the Plan Sponsor shall instruct the Record Keeper on an annual or more frequent basis to allocate the entire balance, less any expenses charged to the Employee After-Tax Contribution Trust under Section 8.4, of the Employee After-Tax Contribution Trust's forfeiture account on an equal (per Participant, flat-dollar) basis to the Employee After-Tax Contribution Accounts of all Participants (whether or not a current Employee) who, on the date of such allocation, have a positive balance in their Employee After-Tax Contribution Accounts.

(d) Neither the Participant, Spouse, Domestic Partner, Dependent Children, nor Dependent Relatives shall have any right to use any portion of the forfeited balance of the Participant's Accounts.

ARTICLE VI: HEALTH INSURANCE COVERAGE

6.1 Eligibility for Health Insurance Coverage.

(a) Subject to the requirements and limitations established in this Article VI and the terms of the Health Insurance Plan Options, the following individuals shall be eligible to enroll in Health Insurance Coverage:

(1) a Participant who has satisfied the criteria for Retirement Eligibility and who has separated from service with the Employer,

(2) the Spouse (or Domestic Partner) of a Participant described in subparagraph (1), and

(3) the Dependent Children of a Participant described in subparagraph (1), except as may otherwise be agreed between the Health Insurer and Emeriti acting on behalf of the Emeriti Program.

(b) In addition to the persons described in subparagraph (a), former Employees of the Employer who are retired as of the Effective Date of the Plan and who are identified by the Plan Sponsor in the Adoption Agreement shall be entitled to enroll in Health Insurance Coverage, subject to the terms and conditions established by the Plan Sponsor in the Adoption Agreement and subject to the following:

(1) The enrollment period for former Employees enrolled under this subsection (b) shall be a period commencing no more than ninety (90) days prior to the first date on which such coverage may commence under the Plan and ending ninety (90) days after this commencement date.

(2) Such coverage shall be subject to the approval of Emeriti and the Health Insurer (and consistent with the terms of any contracts entered into by the Plan Sponsor and Emeriti or the Plan Sponsor and the Health Insurer).

(c) A person described in subsections (a) or (b) shall be eligible for enrollment in Health Insurance Coverage only if he or she is a resident of the United States, and such U.S. Territories in which Health Insurance Coverage may be made available by the Health Insurer.

(d) Dependent Relatives shall not be eligible to enroll in Health Insurance Coverage under the Plan.

(e) In the event that a Participant ceases to be employed by the Employer (for any reason including death) prior to satisfying the criteria for Retirement Eligibility, neither the Participant, his or her Spouse (or Domestic Partner) or Dependent Children shall be eligible to enroll in Health Insurance Coverage, notwithstanding

his or her eligibility for Reimbursement Benefits under Article VII (REIMBURSEMENT BENEFITS).

6.2 Enrollment.

(a) Enrollment of Participant. A Participant described in Section 6.1(a) shall be eligible to enroll in the following Health Insurance Coverage:

(1) a Post-65 Health Insurance Plan Option, but only if the Participant enrolls within the ninety (90)-day period commencing on the later of the date on which the Participant (i) ceases employment with the Employer, (ii) attains age sixty five (65), and (iii) enrolls in Medicare Parts A and B; and

(2) a Pre-65 Health Insurance Plan Option, but only if such coverage is offered by the Health Insurer, the Participant has not enrolled in Medicare Parts A and B, and he or she enrolls within the ninety (90)-day period commencing on the later of the date on which the Participant (i) ceases employment with the Employer and (ii) attains the minimum age at which such insurance coverage may commence.

(b) Enrollment of Spouse (or Domestic Partner) and Dependent Children. At the same time that a Participant enrolls in Health Insurance Coverage, or subsequent to the Participant's enrollment, he or she may enroll his or her Spouse (or Domestic Partner) and/or Dependent Children, subject to the following:

(1) On or after the Spouse's (or Domestic Partner's) enrolling in Medicare.

(a) If the Spouse (or Domestic Partner) has already attained age sixty five (65) and enrolled in Medicare Parts A and B when the Participant becomes entitled to enroll in Health Insurance Coverage, the Spouse (or Domestic Partner) shall be entitled to enroll in a Post-65 Health Insurance Plan Option, provided he or she enrolls within the ninety (90)-day period commencing on the date the Participant becomes eligible to enroll.

(b) If the Spouse (or Domestic Partner) attains age sixty five (65) and enrolls in Medicare Parts A and B during or after the ninety (90) period described in subsection (a), then he or she shall be entitled to enroll in a Post-65 Health Insurance Plan Option, provided he or she enrolls within the ninety (90)-day period commencing on the later of his or her attaining age sixty five (65) and enrolling in Medicare Parts A and B.

(2) Prior to the Spouse's (or Domestic Partner's) enrolling in Medicare.

(a) If the Spouse (or Domestic Partner) has not attained age sixty five (65) (or has attained age sixty five (65) but is not enrolled in Medicare Parts A and B), when the Participant becomes entitled to enroll in Health Insurance Coverage, he or she shall be entitled to enroll in a Pre-65 Health Insurance Plan Option, provided he or she satisfies the eligibility requirements for such Pre-65 Health Insurance Plan Option and enrolls within the ninety (90)-day period commencing on the date the Participant becomes eligible to enroll in Health Insurance Coverage.

(b) If after enrolling in a Pre-65 Health Insurance Plan Option the Spouse (or Domestic Partner) enrolls in Medicare Parts A and B, he or she shall enroll in a Post-65 Health Insurance Plan Option within the ninety (90)-day period commencing on the date on which he or she enrolled in Medicare Parts A and B.

(3) Enrollment of Dependent Children. A Dependent Child shall be entitled to enroll in a Pre-65 Health Insurance Plan Option provided (i) Dependent Children are covered by the option, (ii) the Dependent Child satisfies the eligibility requirements for such option, and (iii) he or she enrolls within the ninety (90) day period commencing on the date the Participant becomes eligible to enroll in Health Insurance Coverage. It shall be within the discretion of the Health Insurer to determine the extent to which a Health Insurance Plan Option covers Dependent Children, no children, or only children who qualify as dependents under Internal Revenue Code Section 152(a)(1).

(c) Exceptions relating to enrollment.

(1) If an eligible Participant, Spouse (or Domestic Partner) or Dependent Child is not enrolled in Health Insurance Coverage within the applicable period described in the preceding subsections of this Section 6.2, his or her enrollment shall not be permitted, except in the following circumstances:

(i) Option to Forego Pre-65 Coverage. An eligible Participant, Spouse (or Domestic Partner) who does not enroll in a Pre-65 Health Insurance Plan Option within the applicable period shall be entitled to enroll in a Post-65 Health Insurance Plan Option within the applicable ninety (90)-day period described in subsections (a)(1) and (b)(1).

(ii) Death of the Participant. An eligible Spouse (or Domestic Partner) or Dependent Child, who does not enroll in a Health Insurance

Plan Option within the applicable period shall be entitled to enroll upon the death of the Participant in accordance with Section 6.3.

(iii) Occurrence of Qualifying Life Events. An eligible Participant, Spouse (or Domestic Partner) or Dependent Child who does not enroll in Health Insurance Coverage within the applicable period shall be entitled to enroll in Health Insurance Coverage upon the occurrence of a qualifying life event described in Section 6.5.

(iv) Other conditions. Absent the applicability of the foregoing paragraphs of this subsection (c)(1), enrollment in Health Insurance Coverage shall not be permitted except as agreed by the Health Insurer and the Plan Sponsor based upon their assessment of unusual circumstances, which may arise from time to time.

(2) Permanently Disabled at time of enrollment. If an eligible Participant, Spouse or (Domestic Partner) or Dependent Child is Permanently Disabled at the time of enrollment, Section 6.4 shall apply.

(d) Effect of Election of Health Insurance Plan Option. Effective commencing on January 1, 2014, a Spouse (or Domestic Partner) or Dependent Child shall be entitled to enroll in a Health Insurance Plan Option different than the Health Insurance Plan Option in which the Participant is enrolled, subject to limitations that may be agreed upon by the Health Insurer and Emeriti.

6.3 Effect of Participant's Death on Health Insurance Coverage.

(a) Eligibility following Participant's death. Following the death of a Participant, the Spouse (or Domestic Partner) and any Dependent Child of the Participant shall be entitled to enroll in Health Insurance Coverage provided that:

(1) the Participant had satisfied the criteria for Retirement Eligibility prior to his or her death;

(2) the Participant was not barred from enrolling in Health Insurance Coverage at the time of his or her death as a result of failing to enroll within the applicable period described in Section 6.2; and

(3) the Spouse (or Domestic Partner) or Dependent Child is not barred from enrolling in Health Insurance Coverage as a result of failing to enroll within the applicable period described in Section 6.2 and enrolls in accordance with this Section 6.3.

(b) Death of Participant Prior to Enrollment. If the Participant dies prior to ceasing employment with the Employer or dies after ceasing employment with the Employer but prior to having enrolled in Health Insurance Coverage:

(1) his or her Spouse (or Domestic Partner) shall be entitled to enroll in Health Insurance Coverage under Section 6.2(b)(1) if he or she was enrolled in Medicare Parts A and B at the time of the Participant's death and under Section 6.2(b)(2) if he or she was not enrolled in Medicare Parts A and B at the time of the Participant's death, and

(2) his or her Dependent Children shall be entitled to enroll in Health Insurance Coverage under Section 6.2(b)(3),

except in each case the applicable ninety (90)-day enrollment period shall commence on the date of the Participant's death.

(c) <u>Death of Participant Post-Enrollment.</u> If the Participant dies after having enrolled in Health Insurance Coverage:

(1) if enrolled in Health Insurance Coverage at the time of the Participant's Death, the Participant’s Spouse (or Domestic Partner) and Dependent Children may remain enrolled in the same Health Insurance Plan Options in which each is enrolled for as long as he or she remains eligible for Health Insurance Coverage and the Health Insurance Plan Option, subject to the following:

(i) he or she shall be permitted to change the Health Insurance Plan Option during any subsequent annual open enrollment period; and

(ii) a Spouse (or Domestic Partner) who is enrolled in a Pre-65 Health Insurance Plan Option shall change enrollment to a Post-65 Health Insurance Plan Option upon attaining age sixty five (65) and enrolling in Medicare Parts A and B in accordance with Section 6.2(b)(2).

(2) if not enrolled in Health Insurance Coverage at the time of the Participant's Death, the Participant's Spouse (or Domestic Partner) and Dependent Children are entitled to enroll in Health Insurance Coverage, subject to the following:

(i) the Participant’s Spouse (or Domestic Partner) shall be entitled to enroll in Pre-65 Health Insurance Plan Option or Post-65 Health Insurance Plan Option (depending on age and whether enrolled in Medicare Parts A and B), provided he or she does so within the ninety (90)-day period commencing on the date of the Participant's death;

(ii) if the Spouse (or Domestic Partner) described in the preceding paragraph (i) does not enroll in a Pre-65 Health Insurance Plan Option, he or she shall be entitled to an additional ninety (90)-day

period commencing on the later of the date he or she attains age sixty five (65) or enrolls in Medicare Parts A and B to enroll in a Post-65 Health Insurance Plan Option; and

(ii) Dependent Children shall be entitled to enroll in a Pre-65 Health Insurance Plan Option, provided they do so within either the ninety (90)-day period commencing on the date of the Participant's death or the ninety (90)-day period provided to the Spouse (or Domestic Partner) in paragraph (ii).

6.4 Health Insurance Coverage for the Permanently Disabled

(a) Permanent Disability of Participant Prior to Retirement Eligibility. In the event that a Participant ceases to be employed by the Employer due to becoming Permanently Disabled prior to satisfying the criteria for Retirement Eligibility, the following rules shall apply:

(1) Enrollment of Participant. A Participant who has received a determination of permanent disability from the Social Security Administration and enrolls in Medicare Parts A and B based on such determination, shall be Permanently Disabled and eligible to enroll in a Post-65 Health Insurance Plan Option within the ninety (90)-day period commencing on the date on which he or she has enrolled in Medicare Parts A and B.

(2) Other Provisions.

(i) The provisions of Section 6.2 shall apply to the Permanently Disabled Participant's enrollment and that of his or her Spouse (or Domestic Partner) and Dependent Children, except that the applicable ninety (90)-day period shall be the period described in the preceding paragraph (1).

(ii) If a Participant has severed service with the Employer and has not satisfied the continuous service requirements established in the Adoption Agreement to avoid forfeiture of Employer Contributions upon termination of employment, the requirements of Section 5.8(b)(1) shall apply.

(b) Permanently Disability of Spouse (or Domestic Partner) or Dependent Child.

(1) Disabled at Time of Participant's Enrollment. If a Spouse (or Domestic Partner) or a Dependent Child is Permanently Disabled and enrolled in Medicare Parts A and B, then at the time that the Participant enrolls in Health Insurance Coverage, the Participant may elect to enroll such person in the Post-65 Health Insurance Plan Option, except as otherwise permitted by the terms of the available Health Insurance Plan Options available, established by agreement between Emeriti and the Insurer.

(2) Disabled after Enrollment in Pre-65 Health Insurance Plan Option. If a Spouse (or Domestic Partner) or a Dependent Child who is enrolled in a Pre-65 Health Insurance Option later becomes Permanently Disabled and enrolled in Medicare Parts A and B, the Participant (or such person) shall notify the Health Insurer and Benefits Administrator to change enrollment to a Post-65 Health Insurance Plan Option, except as otherwise permitted by the terms of the available Health Insurance Plan Options established by agreement between Emeriti and the Health Insurer.

(3) Disabled at Time of Enrollment after Participant's Death. If a Spouse (or Domestic Partner) or a Dependent Child is Permanently Disabled and enrolled in Medicare Parts A and B, then at the time he or she enrolls in Health Insurance Coverage as permitted under Section 6.3(b), he or she may enroll only in a Post-65 Health Insurance Plan Option.

(4) Not Disabled at Time of Enrollment after Participant's Death. If a Spouse (or Domestic Partner) or a Dependent Child who is enrolled in a Pre-65 Health Insurance Plan Option becomes Permanently Disabled and enrolls in Medicare Parts A and B, he or she shall notify the Health Insurer and Benefits Administrator to change his or her enrollment from a Pre-65 to a Post-65 Health Insurance Plan Option.

6.5 Special Enrollment Rights for Qualifying Life Events.

(a) If an eligible Participant, Spouse (or Domestic Partner), or Dependent Child fails to enroll in Health Insurance Coverage within the applicable period provided in Sections 6.2, 6.3 and 6.4, he or she shall be barred from ever enrolling in Health Insurance Coverage except in the case of any of the following events:

(1) he or she was enrolled in COBRA continuation coverage (or the College's Health Insurance Continuation Plan (HICuP)), under another plan and the maximum coverage period has since expired; or

(2) he or she had coverage under another group health plan or had other health insurance coverage and that other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated (including loss of coverage due to legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing events; but not including loss due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

In either case described in paragraphs (1) and (2), if not already enrolled, the Participant must enroll in order for the Spouse (or Domestic Partner) or Dependent Child, as applicable, to enroll. Such Health Insurance Coverage shall be effective the first of the month following the date the completed request for enrollment is received by the Plan.

(b) The Participant acquires a new Spouse (or Domestic Partner), in which case the new Spouse (or Domestic Partner) may be enrolled in Health Insurance Coverage, provided that the Participant is enrolled or simultaneously enrolls in Health Insurance Coverage, and such Health Insurance Coverage shall be effective for each enrollee on the first of the month following the date the completed request for enrollment is received by the Plan.

(c) The Participant acquires a new Dependent Child by marriage, in which case the new Dependent Child may be enrolled in Health Insurance Coverage, provided that the Participant is enrolled or simultaneously enrolls in Health Insurance Coverage, and such Health Insurance Coverage shall be effective for each enrollee on the first of the month following the date the completed request for enrollment is received by the Plan. The addition of a new Dependent Child shall not result in a special enrollment right for existing Dependent Children who were not timely enrolled.

(d) The Participant acquires a new Dependent Child by birth, adoption, or placement for adoption, in which case the new Dependent Child may be enrolled in Health Insurance Coverage, provided that the Participant is enrolled or simultaneously enrolls in Health Insurance Coverage and the Participant's Spouse (or Domestic Partner) may elect simultaneously to enroll in Health Insurance Coverage (if not enrolled already), and such Health Insurance Coverage shall be effective for each enrollee on the date the individual becomes a Dependent Child; provided, however, that the effective date for the Participant and the Participant's Spouse (or Domestic Partner) shall be no earlier than the date permitted by Medicare. The addition of a new Dependent Child shall not result in a special enrollment right for existing Dependent Children who were not timely enrolled.

(e) An individual who is eligible for enrollment under this Section 6.5 must enroll in a Health Insurance Plan Option for which he or she is eligible within thirty (30) days of the qualifying life event.

(f) A Participant who is already enrolled in Health Insurance Coverage may enroll an individual who becomes a Dependent Child within thirty (30) days of that individual becoming a Dependent Child, even if such individual became a Dependent Child as a result of an event other than one described in subsections (c) or (d) above. However, a Participant who is not enrolled in Health Insurance Coverage may not enroll in Health Insurance Coverage by reason of an individual becoming his or her Dependent Child, except as described above.

(g) The Health Insurer may require the Participant and/or individual to submit proof of eligibility as a condition of the coverage provided under this Section 6.5 becoming effective.

6.6 Annual Open Enrollment Election Period.

(a) The Plan shall hold an annual open enrollment period at such time and for such duration as agreed to by Emeriti, the Benefits Administrator, and the Health Insurer, for the purpose of permitting Participants and Spouses (or Domestic Partners) who are currently enrolled in the various Health Insurance Plan Options to elect coverage under any other Health Insurance Plan Option for which they may be eligible.

(b) Participants and Spouses (or Domestic Partners) who are currently enrolled and do not wish to change to another Health Insurance Plan Option shall not be required to reenroll during the open enrollment period, except to the extent required under Medicare.

(c) The annual open enrollment period shall satisfy all requirements imposed under Medicare.

6.7 Effectiveness Date and Effectiveness of Health Insurance Coverage.

(a) Health Insurance Coverage provided under a Post-65 Health Insurance Plan Option commences on the first of the month following the date the individual enrolls in the Health Insurance Plan Option and the Health Insurer accepts such enrollment (and, if applicable, such enrollment is approved by the Centers for Medicare and Medicaid Services), but no earlier than the first of the month in which the individual has attained age sixty five (65), ceased employment with the Employer, and enrolled in Medicare Parts A and B.

(b) Health Insurance Coverage provided under a Pre-65 Health Insurance Plan Option commences on the first of the month following the date the individual enrolls in the Pre-65 Health Insurance Plan Option and the Health Insurer accepts such enrollment.

(c) The initial and continued effectiveness of any Health Insurance Plan Option with respect to any individual shall be contingent upon such individual’s initial and continued eligibility for Health Insurance Coverage under the Plan, and the terms of the Health Insurance Plan Option, the application of Sections 6.8 and 6.9, and in the case of any Post-65 Health Insurance Plan Option, the individual’s enrollment in Medicare Parts A and B.

6.8 Coordination of Coverage.

(a) Loss of Coverage Due to Enrollment in another Plan of the Plan Sponsor. If an individual is eligible for Health Insurance Coverage under this Plan and another plan of the Plan Sponsor, eligibility for coverage under this Plan shall be suspended until such time as eligibility for coverage under the other plan has ceased.

(b) Loss of Coverage Due to Enrollment in another Plan Sponsor's Emeriti Plan. If a Participant enrolls in Health Insurance Coverage under another plan sponsor's plan under the Emeriti Program (an "Emeriti Plan"), such Participant shall cease to be eligible to enroll in Health Insurance Coverage under this Plan (notwithstanding the fact that such Participant has met the criteria for Retirement Eligibility under this Plan); provided, however, that if the plan sponsor sponsoring the other Emeriti Plan ever withdraws from the Emeriti Program, the Participant's eligibility to enroll in Health Insurance Coverage under this Plan shall be reinstated. This subsection (b) shall also apply to a Participant's Spouse (or Domestic Partner) and Dependent Children.

(c) Coordination with Active Plan to Comply With Medicare. No Participant, Spouse (or Domestic Partner), or Dependent Child who is enrolled in Medicare but remains eligible for the Employer's active employee health plan shall be permitted to enroll in a Post-65 Health Insurance Plan Option under this Plan. Once such individual's eligibility under the Employer's active employee health plan ceases, such individual may enroll in a Post-65 Health Insurance Plan Option if he or she is eligible under the other provisions of this Article VI.

(d) Married Participants/Domestic Partner Participants. Additional rules applicable to Participants who are Spouses of each other (or are Domestic Partners of each other) are at Appendix A.

6.9 Cessation of Health Insurance Coverage.

(a) Cessation Due to Loss of Status. A Spouse's (or Domestic Partner's) or Dependent Child's Health Insurance Coverage shall cease on the last day of the month in which such individual fails to satisfy the requirements of a Spouse (or Domestic Partner) or Dependent Child, as applicable (whether prior to or following the death of the Participant). A Spouse's Health Insurance Coverage shall cease on the last day of the month in which a court of competent jurisdiction enters an order that the Participant and Spouse are legally separated, except as otherwise provided under Article X (COBRA CONTINUATION COVERAGE).

(b) Cessation due to non-payment of premiums. Initial and continued eligibility for Health Insurance Coverage is conditioned upon the payment of Health Insurance Premiums for the applicable Health Insurance Plan Option. Unless otherwise provided under the terms of the applicable Health Insurance Plan Option and

except as otherwise required by law, coverage shall terminate for non-payment of premiums on the last day of the second month for which premiums have not been paid. In the event that Medicare or other law requires coverage of a Participant or other individual during a period in which no Health Insurance Premium has been paid by the Participant or such other individual in violation of the terms of the Plan, such Health Insurance Premiums shall be paid from the Plan’s forfeiture account unless otherwise paid by the Employer. In the event that the Plan’s forfeiture account is insufficient, the Employer shall be responsible for payment of such Health Insurance Premiums.

(c) Coverage Ends on Last Day of Month. Except with respect to the treatment of delinquent premiums in the preceding subsection, in the event that an individual’s Health Insurance Coverage ends for any reason other than death, coverage shall cease on the last day of the month in which such coverage ends, unless otherwise provided.

(d) Cancellation of Coverage. In the event that a Participant's, Spouse's (or Domestic Partner's), or Dependent Child's Health Insurance Coverage is cancelled due to:

(1) the non-payment of Health Insurance Premiums;

(2) the failure to abide by the terms and conditions of such Health Insurance Coverage;

(3) his or her voluntary action (or that of a person acting on his or her behalf); or

(4) the requirements under Medicare,

he or she shall thereafter be ineligible to enroll in Health Insurance Coverage unless expressly permitted by the Health Insurer.

(e) Medicare Requirements. Notwithstanding anything herein to the contrary, in no event shall Health Insurance Coverage terminate prior to the date permitted under Medicare.

6.10 Insurers.

The Employer, Emeriti, Record Keeper, Benefits Administrator and Trustee shall not be responsible for the validity of any insurance policy, or provisions of such policy, issued by the Health Insurer or the issuer of Other Health Insurance, nor for the claims determinations of the Health Insurer or the issuer of Other Health Insurance or benefits due under any such policy. The Health Insurer and any issuer of Other Health Insurance shall be solely responsible for providing the Health Insurance Benefits or Other Health Insurance benefits, as applicable, but shall not be responsible for the design of the Plan or any decision or action of Emeriti, the Record Keeper or the Benefits Administrator.

ARTICLE VII: REIMBURSEMENT BENEFITS

7.1 Eligibility for Reimbursement Benefits.

Subject to the requirements and limitations established in this Article VII (including with respect to who may submit claims on their behalf), the following persons shall be eligible for Reimbursement Benefits:

(a) in the case of funds to be drawn against an Employer Contribution Account, a Participant who has ceased employment and meets the requirements for Retirement Eligibility under the Adoption Agreement;

(b) in the case of funds to be drawn against an Employee After-Tax Contribution Account, a Participant who ceased employment with the Employer, and

(c) the Spouse, Domestic Partner, Dependent Child, or Dependent Relative of any Participant identified in the preceding subsections (a), and (b).

7.2 Amount Available.

(a) Available Balance. Reimbursement Benefits shall be paid from the available balance in a Participant's Employee After-Tax Contribution Account and Employer Contribution Account.

(b) Amount Paid. The Reimbursement Benefits paid shall equal the value of the substantiated claim(s) for Qualified Medical Expenses submitted in accordance with Section 7.8, subject to the limitations described in this Article VII. In no event shall the amount paid exceed the available balance.

7.3 Terminal Illness or Injury.

A Participant otherwise described in Section 7.1-who does not meet the requirements for Retirement Eligibility under the Adoption Agreement shall nonetheless be eligible for Reimbursement Benefits for Terminal Illness or Injury Expenses incurred by the Participant, his or her Spouse (or Domestic Partner), Dependent Child, or, subject to an election in the Adoption Agreement, Dependent Relative upon satisfaction of the requirements of Section 5.01(b)(2) and this Section 7.3. For purposes of this Article VII, the term "Terminal Illness or Injury Expenses" shall mean any Qualified Medical Expenses of the terminally ill or injured individual which are incurred within one (1) year prior to, or at any time following, the date of certification by the individual's physician that the individual has suffered an illness or injury expected to result in such individual's death within five (5) years of the date of certification, provided that the certification is received by the Plan Sponsor within twelve (12) months following termination of employment.

7.4 Catastrophic Medical Expenses.

A Participant otherwise described in Section 7.1 who does not meet the requirements for Retirement Eligibility under the Adoption Agreement but who submits to the Benefits Administrator valid evidence of Qualified Medical Expenses incurred by the Participant, his or her Spouse (or Domestic Partner), Dependent Children, and, subject to an election in the Adoption Agreement, Dependent Relatives that cumulatively exceed $15,000 in the aggregate and were incurred during a single 12-month period shall be eligible for Reimbursement Benefits equal to that portion of these Qualified Medical Expenses that exceeds $15,000. Such valid evidence must be submitted as part of a single claim for Reimbursement Benefits above that amount within twelve (12) months following termination of employment.

7.5 Coordination with HSAs and FSAs.

(a) A Participant who participates in a high deductible health plan (“HDHP”) and is currently eligible to contribute to a health savings account (“HSA”) as described in Section 223 of the Internal Revenue Code shall not be eligible for Reimbursement Benefits unless such Participant has first satisfied the HDHP’s minimum annual deductible for the year in which the Qualified Medical Expenses were incurred; and

(b) A Participant who elects coverage under a health flexible spending arrangement (“FSA”) as described in the Treasury Regulations under Section 125 of the Internal Revenue Code shall not be eligible for Reimbursement Benefits unless such Participant has first exhausted the maximum annual coverage amount available to the Participant under the FSA for the year in which the Qualified Medical Expenses were incurred.

7.6 Effect of Participant’s Death on Reimbursement Benefits.

If the Participant dies at any time, the person identified in Section 7.8(b) may submit claims for Reimbursement Benefits for the following persons: the deceased Participant for any claims incurred in the year prior to his or her death and the Participant’s Spouse (or Domestic Partner), Dependent Children, and Dependent Relatives, each of whom shall be immediately eligible for Reimbursement Benefits payable from the available balance in the Participant’s Accounts, which shall be determined in accordance with Section 7.2.

7.7 Submission of Claims.

Only the following person(s) may submit claims for the reimbursement of Qualified Medical Expenses:

(a) Prior to the death of the Participant, only the Participant (or his or her legal representative in the event of incapacity) may submit claims.

(b) Upon the death of the Participant, only the person controlling the Participant's Accounts based upon the application of Section 5.7 may submit claims.

7.8 Cessation of Reimbursement Benefits.

(a) Reimbursement Benefits shall cease upon the earlier of the following dates:

(1) whenever the available balances of the Participant’s Employer-Contribution Account and Employee After-Tax Contribution Account reach zero dollars ($0); or

(2) whenever the last person eligible for Reimbursement Benefits dies or becomes ineligible for Reimbursement Benefits.

(b) If no person remains eligible for Reimbursement Benefits and a residual balance remains in the Participant’s Accounts, the residual balance shall be forfeited and used in accordance with Sections 5.8 and 5.9.

ARTICLE VIII – PLAN ADMINISTRATION

8.1 Plan Administrator.

The administration of the Plan shall be under the supervision of the Plan Sponsor, whose principal duty shall be to see that the Plan is carried out in accordance with its terms for the exclusive benefit of Participants, Spouses, Domestic Partners, Dependent Children, and Dependent Relatives. The Plan Sponsor shall have sole discretion and authority to interpret and administer the Plan in all of its details, subject to applicable requirements of law, and shall be responsible for complying with the reporting and disclosure obligations imposed under applicable federal and state law, including, except in the case of a plan established by a Governmental Entity, Part 1 of Subtitle B of Title I of ERISA. The determination of the Plan Sponsor (or its delegate) as to any question involving the administration and interpretation of the Plan shall be final, conclusive, and binding. For this purpose, the Plan Sponsor's powers and responsibilities as administrator will include, but not be limited to, the following, in addition to all other powers and responsibilities provided by this Plan:

(a) to make and enforce such rules and regulations as it deems necessary and proper for the efficient administration of the Plan;

(b) to exercise discretion in interpreting the Plan (any interpretation reviewed by a court to be reviewed under the arbitrary and capricious standard);

(c) to appoint and monitor such agents, counsel, accountants, auditors, consultants, and other persons as may be required to assist in administering the Plan;

(d) to allocate and delegate its administrative responsibilities under the Plan, and to designate other persons to carry out any of its administrative responsibilities, any such allocation, delegation, or designation to be in writing. Any such allocation, delegation, or designation set forth in the Plan or in the Membership Contract need not be separately set forth in writing. Subject to the terms of the Membership Contract and the express delegations set forth in the Plan, the Plan Sponsor may remove any such person for any reason at any time, and any such person may resign at any time by giving written notice to the Plan Sponsor;

(e) to prepare and distribute to each Participant (and to the extent required by ERISA, to each Spouse, Domestic Partner, Dependent Child, and Dependent Relative) the following documents: a summary plan description and summary of material modifications of the Plan as required by ERISA (or any similar document required under any applicable state law), and the initial notice of COBRA rights required by COBRA, each of which shall be provided to the required parties at the time an individual becomes a Participant and again at the time a Participant first becomes eligible for benefits;

(f) to prepare, execute and file (and, as relevant, distribute to Participants) all reports or other filings necessary to meet the reporting and disclosure requirements under applicable federal and state law, including the requirements imposed under ERISA that are the responsibility of "administrators" under ERISA (except in the case of a plan established by a Governmental Entity), and any similar requirements that may be imposed under state law, including, but not limited to Form 1024, Form 990, Form 5500, and the summary annual report;

(g) to ensure that the Plan is audited by a qualified, independent auditor as necessary to satisfy the requirements of applicable federal and state law, including, except in the case of a plan established by a Governmental Entity, ERISA ; and

(h) to comply with any other applicable federal or state laws and regulations that may be enacted or promulgated.

8.2 Delegation.

(a) Delegation generally. To the extent permitted by law, the Plan Sponsor and any person to whom it allocates or delegates administrative responsibilities under the Plan (or whom it designates to carry out any of its administrative responsibilities) shall be entitled to rely conclusively upon, and shall be fully protected in any action taken or suffered by them in good faith in the reliance upon, any counsel, accountant, other specialist or other person selected by the Plan Sponsor or such person, or in reliance upon any tables, valuations, certificates, opinions or reports that shall be furnished by any of them or by the Trustee. To the extent permitted by law, the Plan Sponsor and each such person shall not be liable for any neglect, omission or wrongdoing of the Trustee or of any other person to whom powers or responsibilities with respect to the Plan have been delegated.

(b) Delegation to Emeriti. For the purpose of enabling Emeriti to manage the Emeriti Program consistently across all Plans within the Program, the Plan Sponsor, in its capacity as administrator of the Plan, delegates to Emeriti the following administrative responsibilities and corresponding powers during the term of the Membership Contract:

(1) to make and enforce rules and regulations,

(2) to interpret the Plan,

(3) to resolve any ambiguity or inconsistency in the terms of the Plan, and

(4) to allocate and delegate responsibilities under the Plan and to designate other persons to carry out any responsibilities

as Emeriti deems necessary or proper for the purpose of managing the Emeriti Program consistently across all Plans within the Program. Notwithstanding this

delegation, the Plan Sponsor, in its capacity as administrator of the Plan, shall retain all residual administrative responsibilities and corresponding powers, and shall have the residual responsibility to monitor Emeriti with respect to its delegated authority.

8.3 Record Keeper and Benefits Administrator.

(a) The Record Keeper and Benefits Administrator shall carry out the duties allocated to them under the Plan, which shall be ministerial in nature. In carrying out their duties under the Plan, neither the Record Keeper nor the Benefits Administrator is an "administrator" or a "fiduciary" of the Plan within the meaning of Section 3(16)(A) and 3(21) of ERISA (or, where applicable, within the meaning of similar provisions of State law). The Record Keeper and Benefits Administrator shall consult with the Plan Sponsor, or its delegate, in the event that direction is absent or unclear, except with respect to the administration of the Plan within the Program where Emeriti has administrative authority under Section 8.2, in which case the Record Keeper and Benefits Administrator shall consult with Emeriti.

(b) The Record Keeper and Benefits Administrator may establish reasonable administrative procedures and rules relating to their ministerial duties, which shall be consistent with the fair and efficient administration of the Plan and subject to the approval of Emeriti, including but not limited to procedures and rules relating to (i) the Employer's remittance of contributions and plan- and participant-level information; (ii) the verification of any person's identity and status under the Plan, (iii) the Plan Sponsor's selection of the investment menu for the Plan, (iv) the investment of Accounts and Account transactions, and (v) the submission of claims for Reimbursement Benefits.

(c) The Benefits Administrator and Health Insurer may establish reasonable administrative procedures and rules pertaining to enrollments in Health Insurance Coverage and election of Health Insurance Plan Options, which shall be comply with any applicable federal and state laws, consistent with the fair and efficient administration of the enrollment process, and subject to the approval of Emeriti.

8.4 Plan Expenses.

Subject to the terms of the Membership Contract and the Adoption Agreement, all reasonable expenses, as determined by the Plan Sponsor, that shall arise in connection with the administration of the Plan, including, but not limited to, the expenses incurred by any committee in carrying out its duties and responsibilities under the Plan, the compensation of the Trustee, administrative expenses and other proper charges and disbursements of the Trustee or a committee, and compensation and other expenses and charges of any counsel, accountant, specialist, agent or other person who shall be employed by the Plan Sponsor or a committee in connection with the administration thereof, may be charged to the Trusts and paid by the Trustee. Forfeiture accounts, Participants' Accounts or, in the case of ACH Transfers, Participants' private bank or

similar accounts may be charged by the Plan Sponsor or upon its direction for part or all of the reasonable expenses of administration of the Plan, consistent with applicable law.

8.5 Provision of Information.

Participants, Spouses, Domestic Partners, Dependent Children, and Dependent Relatives shall provide the Plan Sponsor (or its agents or delegates) with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan and ensuring the continued accuracy of information previously provided. Neither the Record Keeper, Benefits Administrator, Trustee or Health Insurer shall have any responsibility to verify the accuracy of any information provided to it by any such individuals, subject to any intervening obligations that each may have under the terms of their contractual agreements with Emeriti or the Plan Sponsor, or under applicable law.

8.6 Designation of Dependents.

A Participant (or, in the event of the Participant's death, the person controlling the Participant's Accounts in accordance with Section 5.7) shall be responsible for designating or identifying the Participant's Spouse (or Domestic Partner), Dependent Children, and Dependent Relatives and for updating the information as necessary to maintain its accuracy in accordance with reasonable procedures that may be established.

ARTICLE IX – CLAIMS PROCEDURES

9.1 Payment, Reimbursement and Refund of Health Insurance Premiums.

(a) A Participant enrolled in Health Insurance Coverage under the Plan (or the person controlling the Participant's Accounts based on the application of Section 5.7) shall pay Health Insurance Premiums from the Participant's Accounts in accordance with procedures established by the Benefits Administrator and the Health Insurer and, except as described in Section 10.4(b)(5), shall not file a claim for the payment of the Premiums under Section 9.3, relating to claims for Reimbursement Benefits.

(b) Premiums paid for Other Health Insurance offered outside the Plan shall be claims eligible for Reimbursement Benefits and processed under Section 9.3.

(c) Refunds of Health Insurance Premiums paid for Health Insurance Coverage shall be subject to reasonable procedures of the Health Insurer. In no instance shall refund of such premiums be paid for more than a 90-day coverage period.

(d) In the event that a dispute arises with respect to a Health Insurance Premium payment or refund described in subsections (a), (b), or (c) after the Participant (or other person controlling the Participant's Accounts) has attempted to resolve the issue by contacting the Benefits Administrator [and/or Health Insurer], he or she may file a claim with Emeriti. Such claim shall be submitted within sixty (60) days of the following date, whichever is applicable:

(1) The date on which such Participant (or other person) received notice that his or her Health Insurance Coverage had been cancelled as a result of non-payment of Health Insurance Premiums; or

(2) The date on which an overpayment of Health Insurance Premiums occurred.

9.2 Claims arising from Health Insurance Coverage.

Claims and appeals of denied claims relating to Health Insurance Coverage shall be submitted to the Health Insurer, who shall be solely responsible for administering all such claims in accordance with ERISA (including the Department of Labor Regulations thereunder) and State law, as applicable. The claims procedures governing all claims for Health Insurance Benefits shall be those set forth in the certificate of coverage. The final determination of the Health Insurer on review shall in all cases be final, and neither the Employer nor Emeriti shall have any authority to overrule any determination of the Health Insurer. Under no circumstances shall the Health Insurer be responsible for processing claims for benefits under any Other Health Insurance for which premium payments have been reimbursed from a Participant's Accounts.

9.3 Claims for Reimbursement Benefits.

(a) Submission of Claims. Claims and appeals of denied claims for Reimbursement Benefits shall be submitted to the Benefits Administrator. The initial claim shall be filed no later than twelve (12) months following the end of the calendar year in which the claimed expense was incurred. Failure to file a claim for Reimbursement Benefits within the required time shall not invalidate or reduce any claim if it was not reasonably possible to substantiate the claim within such time, provided such substantiation is furnished as soon as reasonably possible. Written notice given by, or on behalf of, a claimant to the Benefits Administrator at the Benefits Administrator's mailing address listed in the Summary Plan Description, with information sufficient to identify the claimant, shall be deemed notice to the Benefits Administrator of the claimant's claim.

(b) Substantiation of Claims. Required evidence of a Qualified Medical Expense may include, but not be limited to, a bill, receipt, or similar documentation identifying the person(s) for whom the claim was incurred, the nature of the medical service, care or product, the date of the service or care was delivered, or the product purchased, and, if applicable, which the Participant (or person identified under Section 5.7) shall provide to the Benefits Administrator in accordance with its reasonable procedures.

(c) Point-of-service submission**.** In the event the Plan Sponsor makes available the electronic submission of claims for Reimbursement Benefits at point-of-service by use of a debit card (or other technologies), the procedures for, and any limitations on, such submissions shall be established at the discretion of Emeriti and the service providers engaged by Emeriti to implement point-of-service claims submission services, subject to the written approval of the services by the Plan Sponsor for its Plan.

(d) Reimbursement Benefit claims decisions. If a claimant has submitted a claim for Reimbursement Benefits, the Benefits Administrator shall notify the claimant of an approval or denial no later than thirty (30) days after its receipt of the claim. If special circumstances require a fifteen (15)-day extension of time to review the claim, the Benefits Administrator shall notify the claimant prior to the end of the initial thirty (30)-day period of the need for an extension, including the circumstances requiring the extension and the date a decision is expected. The notice of extension shall explain the standards on which entitlement to Reimbursement Benefits is based, the unresolved issues that prevent a decision on the claim within the thirty (30)-day period, and any additional information needed to resolve those issues. If additional information is required from the claimant, the claimant shall be afforded at least forty five (45) days to provide such information. The deadline for making a decision on the claim shall then be extended for forty five (45) days or, if shorter, for the length of time it takes the claimant to provide the additional information.

(e) Notification of Denial. A written notice of claim denial from the Benefits Administrator shall contain the following:

(1) the specific reason or reasons for denial;

(2) reference to specific Plan provisions on which the denial is based;

(3) a description of any additional material or information necessary to perfect the claim, with an explanation of why the material or information is necessary;

(4) an explanation of the claims review procedure and the time limits applicable to such procedure, including, in the case of a Plan established under ERISA, a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial upon review of the claim;

(5) if any internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, an explanation of such criterion or a statement that such criterion will be provided to the claimant free of charge, upon request; and

(6) if the denial is based on medical necessity or experimental treatment or a similar limitation, an explanation of the scientific or clinical judgment on which the determination is based, or a statement that such explanation will be provided to the claimant free of charge, upon request; provided, however, that this subsection (e)(6) shall not apply so long as the Plan Sponsor participates in the Emeriti Program.

(f) <u>Right to Review</u>. A claimant may request review at any time within one hundred eighty (180) days following the date the claimant received written notice of the denial. A failure to file a request for review within one hundred eighty (180) days shall constitute a waiver of the claimant's right to request a review of the denial of the claim.

(g) <u>Review Procedures.</u> The claimant must request review in writing to the Plan Sponsor and must state the claimant's name and address, the fact that the claimant is disputing the denial of a claim, the date of the initial notice of denial, the reason(s) for disputing the denial, and any other information as the Plan Sponsor may reasonably require in order to make a determination upon review of the claim. Such request may be made by electronic means if permitted by the Plan Sponsor. During the review process the Plan Sponsor shall:

(1) provide the claimant, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim;

(2) permit the claimant to submit written comments, documents, records and other information relating to the claim;

(3) provide a review that takes into account all comments, documents, records and other information submitted, without regard to whether such information was submitted or considered in the initial determination;

(4) provide a review that does not afford deference to the initial claim determination and that is conducted by a Plan fiduciary other than the person who conducted the initial claim determination (or a subordinate of that person);

(5) if the decision is based on a medical judgment, consult with a health care professional with experience in the appropriate field; provided, however, that this subsection (g)(5) shall not apply so long as the Plan Sponsor participates in the Emeriti Program;

(6) provide the claimant, upon request, with the identity of those medical experts whose advice was obtained in connection with the claim; provided, however, that this subsection (g)(6) shall not apply so long as the Plan Sponsor participates in the Emeriti Program; and

(7) ensure that any health care professional consulted during the review is someone other than the person consulted in the initial claim determination (or a subordinate of that person); provided, however, that this subsection (g)(7) shall not apply so long as the Plan Sponsor participates in the Emeriti Program.

(h) Notification of Determination on Review. The Plan Sponsor shall notify the claimant of the decision on review (whether favorable or unfavorable) no later than thirty (30) days after receipt of the written request for review. If the claim is denied upon review, in whole or in part, the written notice shall contain the following information:

(1) the specific reason for the decision and specific reference to the provisions of the Plan on which the decision is based;

(2) a statement that the claimant is entitled to receive, upon request and free of charge, copies of all documents, records and other information relevant to the claim for benefits;

(3) a statement describing any voluntary appeal procedures offered by the Plan and, in the case of a Plan established under ERISA, explaining the claimant's right to bring a civil action under Section 502(a) of ERISA following the denial;

(4) if any internal rule, guideline, protocol, or other similar criteria was relied upon in denying the claim, an explanation of such criteria or a statement that such criteria will be provided to the claimant free of charge, upon request; and

(5) if the denial is based on medical necessity or experimental treatment or a similar limitation, an explanation of the scientific or clinical judgment on which the determination is based, or a statement that such explanation will be provided to the claimant free of charge, upon request; provided, however, that this subsection (h)(5) shall not apply so long as the Plan Sponsor participates in the Emeriti Program.

9.4 Facility of Payment.

If a person who is entitled to receive payment under the Plan is physically or mentally incapable of personally receiving and giving a valid receipt for any payment due (unless a previous claim has been made by a duly qualified committee or other legal representative), the payment may be made to the person's personal representative as documented in writing with the Plan Sponsor. The Plan Sponsor may request proof of such individual's relationship to the person entitled to receive payment under the Plan including a copy of a power of attorney, guardianship designation or certification, or other evidence of such authority. Any payment of a benefit or any installment payment of a benefit in accordance with the provisions of this Section 9.4 shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan. In the event that a claimant is deceased at the time payment is to be made to the claimant, payment may be made to the claimant's estate.

9.5 Overpayment of Claims.

(a) Health Insurance Benefits. In the event of an overpayment of Health Insurance Benefits paid under Section 9.2, the rules in the certificate of coverage shall control.

(b) Reimbursement Benefits. In the event of an overpayment of Reimbursement Benefits paid under Section 9.3, the following rules shall apply:

(1) The Plan shall have the power and authority to collect (or instruct another party, such as the Benefits Administrator or Record Keeper to collect) from a Participant, Spouse, Domestic Partner, Dependent Child, Dependent Relative, or other payee the amount of any overpayment, regardless of the cause of the overpayment. With respect to overpayments which are the direct or indirect result of a mistake or an administrative error made by the Benefits Administrator, the Benefits Administrator shall be responsible for correcting its mistake or administrative error and restoring any loss to the Plan.

(2) The Benefits Administrator may take any of the following steps (without limitation) in response to a verified overpayment of any claim under the Plan:

(i) Request repayment from the Participant or other payee;

(ii) Offset the amount of the overpayment against further approved claims with respect to the Participant's Accounts;

(iii) Deduct from the personal bank account of the Participant or other payee; or

(iv) Notify the Plan Sponsor, who may pursue collection of the overpayment through legal procedures instituted on behalf of the Plan.

9.6 Unclaimed Payments.

The right of a claimant to Reimbursement Benefits shall at all times be subject to the requirement that the claimant provide the Benefits Administrator with his or her current address and bank account information. If any check or other instrument in payment of Reimbursement Benefits, which was mailed by regular United States mail (or delivered by electronic funds transfer) to the last known address (or bank account) of the claimant is returned unclaimed, the Benefits Administrator shall notify the Plan Sponsor and shall make no further payment of Reimbursement Benefits to such person until the Benefits Administrator receives the claimant's current address and bank account information from the Plan Sponsor or the claimant. In the event that the Benefits Administrator does not receive notice of the claimant's current address and bank account information within twelve months from the date of the check or other instrument (or electronic funds transfer), then the claimant's right to the particular Reimbursement Benefit shall be suspended. The amount of the payment shall then be returned to the applicable Participant's Account(s) and made available to pay for other Reimbursement Benefits or Health Insurance Premiums, subject to the claimant or Plan Sponsor providing the Benefits Administrator with the claimant's current address.

9.7 Delegation to Independent Third Party Reviewer.

In the event of a claim or appeal made to the Plan Sponsor under sections 9.1(d) and 9.3(g), the Plan Sponsor is authorized to delegate the authority to review and decide the appeal to an independent third party reviewer. In the event of such delegation, the third party reviewer shall perform all of the responsibilities of the Plan Sponsor under sections 9.1(d), 93(g) and 9.3(h). For any claim or appeal that would place the third party reviewer In possession of, and require the third party reviewer to review, HIPAA protected health information, the third party reviewer will be required to enter into a business associate agreement compliant with the HIPAA Privacy Rule.

9.8 Recourse to Litigation.

No action at law or in equity shall be brought to recover on the Plan prior to the time the claimant exhausts the administrative remedies outlined in this Article IX, and no such action shall be brought at all unless brought within one (1) year from the expiration of the time within which final appeal is denied pursuant to this Article IX. The foregoing shall not in any way limit any individual's rights which may be available under federal or state securities laws.

ARTICLE X – COBRA CONTINUATION COVERAGE

10.1 Benefits Subject to COBRA Continuation Coverage.

(a) COBRA Administration. During the term of the Membership Contract, the duties of the "COBRA Administrator" as set forth herein shall be carried out by the Health Insurer(s) or such third party as shall be selected by Emeriti.

(b) Health Insurance Coverage. This Article X applies only to Health Insurance Coverage and shall be interpreted in a manner that causes the Health Insurance Coverage to comply with Section 4980B of the Internal Revenue Code, Sections 300bb-1 through 300bb-8 of the PHSA, and Sections 601 through 608 of ERISA, but that does not create rights not required by those statutory provisions.

(c) Reimbursement Benefits. No COBRA Continuation Coverage or a similar State continuation coverage shall be available under the Plan for Reimbursement Benefits or serve as the basis for a claim to a right to continuation coverage for Reimbursement Benefits, either in the form of access to, or division of, the Participant's Account(s) or by establishment of a separate account for such individual. In the event of any divorce, legal separation, or cessation of Dependent Child status, the right of the Spouse, former Spouse, or former Dependent Child to Reimbursement Benefits under the Plan shall be subject to such individual's establishment of a right to the Participant's Account(s) through a domestic relations order or medical child support order under Article XI (COURT ORDERS).

(d) No COBRA Continuation Coverage shall be available under the Plan for Other Health Insurance.

10.2 Definitions.

For purposes of this Article X, the following terms shall have the following meanings. Any term that is not defined below, but which has an assigned meaning under COBRA, shall have that assigned meaning for purposes of this Article X.

(a) The term "COBRA Continuation Coverage" means continued coverage under the Health Insurance Coverage, as required by COBRA and as described in this Article X.

(b) The term "Qualified Beneficiary" means any individual who, on the day before a Qualifying Event, is a Participant's Spouse or Dependent Child and is enrolled in Health Insurance Coverage. A Qualified Beneficiary who fails to elect COBRA Continuation Coverage under this Article X in connection with a Qualifying Event ceases to be a Qualified Beneficiary at the end of the election period specified in Section 10.5.

(c) The term "Qualifying Event" means an event that satisfies each of the following subsections (1) and (2):

(1) An event satisfies this subsection (1) if it is the divorce or legal separation of the Spouse from the Participant, or a Dependent Child ceasing to be a Dependent Child.

(2) An event satisfies this subsection (2) if the event causes the individual identified in subsection (1) above to lose Health Insurance Coverage, including ceasing to be eligible to participate in Health Insurance Coverage under the same terms and conditions as in effect immediately before the Qualifying Event. For purposes of this subsection (2), a loss of Health Insurance Coverage need not occur immediately after the Qualifying Event, so long as the loss of coverage will occur before the end of the maximum coverage period described in Section 10.3. However, if the individual will not lose coverage before the end of what would be the maximum period described in Section 10.3, the event is not a Qualifying Event.

10.3 Period of Coverage.

(a) General. Upon the occurrence of a Qualifying Event as to a Qualified Beneficiary, that Qualified Beneficiary has the right to elect COBRA Continuation Coverage under Health Insurance Coverage to the extent described in Section 4980B(f)(2)(A) of the Internal Revenue Code, Section 300bb-2(1) of the PHSA and Section 602(1) of ERISA and for the period of time provided in Section 4980B(f)(2)(B) of the Internal Revenue Code, Section 300bb-2(2) of the PHSA and Section 602(2)(A) of ERISA.

(b) Early Termination of COBRA Continuation Coverage. Certain events may cause the period of COBRA Continuation Coverage to terminate earlier than the maximum required period. Except as otherwise specified, COBRA Continuation Coverage for a Qualified Beneficiary terminates immediately upon the occurrence of any event listed in the following paragraphs:

(1) The Qualified Beneficiary becomes covered under any other group health plan (as an employee or otherwise), as described in Section 607(1) of ERISA, provided that such plan does not contain any exclusion or limitation with respect to any preexisting condition of such individual.

(2) The Qualified Beneficiary fails to pay in a timely manner the required premium as determined and announced by the COBRA Administrator. If the premium payment is the first payment and if the election of COBRA Continuation Coverage occurs after the Qualifying Event, the premium payment may be made within forty five (45) days after the election. Payment is considered made on the date on which it is sent to the COBRA

Administrator. For purposes of this paragraph, a payment of any premium, other than the first premium, is considered to be timely if the full amount of the premium is paid within thirty (30) days after the premium due date specified by Emeriti. In the event that the full amount of the premium due is not paid within such time, the following rules shall apply:

(i) The deficiency shall be considered "significantly less" than the total premium due if it is greater than the lesser of:

(A) Fifty dollars ($50); or
(B) Ten percent (10%) of the amount of the total premium due.

(ii) If the amount paid is "significantly less" than the total premium due, it shall not be considered timely paid.

(iii) If the amount paid is not "significantly less" than the total premium due, then the COBRA Administrator shall notify the Qualified Beneficiary of the amount of the deficiency. Such notice shall indicate that payment of the deficiency may be made within thirty (30) days after the date the notice is provided. If payment of the deficiency is made within such time, the premium payment shall be considered timely. If payment of the deficiency is not made within such time, the premium payment shall not be considered timely.

(3) The Employer no longer sponsors or maintains any group health plan (including successor plans) for any of its retired employees. For purposes of this paragraph, the term Employer includes an Employer as defined in this Plan and any entity that is a member of a group described in Section 414(b), (c), (m), (n), (o) or (t) of the Internal Revenue Code that includes the Employer, and any successor of either the Employer or such an entity.

(4) The Qualified Beneficiary becomes entitled to Medicare after electing COBRA Continuation Coverage.

(c) Open Enrollment. A Qualified Beneficiary shall have the same right as a similarly situated Spouse or Dependent Child, as applicable, under the Plan to change Health Insurance Plan Options during the Plan's annual open enrollment period.

(d) Medicare Entitlement Prior to Election. If the Spouse becomes a Qualified Beneficiary and is already entitled to Medicare on the date of the election of COBRA Continuation Coverage, he or she shall have the right to elect COBRA Continuation Coverage.

10.4 Premium Requirement.

(a) General. Prior to the determination period to which the premium amount applies, the COBRA Administrator shall determine the appropriate premium for each Qualified Beneficiary entitled to COBRA Continuation Coverage. The COBRA Administrator shall follow the guidelines listed in this Section 10.4, as well as any additional standards provided by statute or regulation, in determining the appropriate premium.

(b) Guidelines:

(1) Except as provided in paragraph (2) below, the premium cannot exceed 102 percent (or any greater percentage permitted by statute) of the cost to the Plan for such period of coverage for similarly situated Spouses or Dependent Children with respect to whom a Qualifying Event has not occurred (without regard to whether such cost is paid by the Employer).

(2) If an election of COBRA Continuation Coverage occurs after the Qualifying Event, the Plan must permit payment of the premium for COBRA Continuation Coverage during the period preceding the election to be made within forty five (45) days after the election.

(3) COBRA Continuation Coverage and the amount of the premium cannot be conditioned upon evidence of insurability or discriminate on the basis of lack of evidence of insurability.

(4) A Qualified Beneficiary who is entitled to and elects COBRA Continuation Coverage shall pay the appropriate premium in monthly installments directly to the COBRA Administrator.

(5) A Qualified Beneficiary who is an "alternate account holder" under Section 11.1 of the Plan shall not be entitled to pay premiums for COBRA Continuation Coverage from his or her Account(s) but may submit such premium payments for Reimbursement Benefits.

10.5 Election Period.

(a) Period. A Qualified Beneficiary who is entitled to elect COBRA Continuation Coverage must make that election within sixty (60) days after the later of the date Health Insurance Coverage ends or the date the affected individual is sent notice of his or her right to elect COBRA Continuation Coverage.

(b) Effect of Spouse's Election on Other Qualified Beneficiaries. Unless the election specifies otherwise, an election of COBRA Continuation Coverage by the Spouse is deemed to include an election of COBRA Continuation Coverage on behalf of

the Spouse and the Dependent Children who are Qualified Beneficiaries as a result of the Qualifying Event.

(c) Time of Election and Waiver. A Qualified Beneficiary's election of COBRA Continuation Coverage is deemed to be made on the date the Qualified Beneficiary's election is sent to the COBRA Administrator. If a Spouse or Dependent Child waives COBRA Continuation Coverage during the election period determined under this Section 10.5, that waiver may be revoked at any time before the end of the election period. If any waiver is revoked before the end of the election period, however, COBRA Continuation Coverage under Health Insurance Coverage is effective prospectively only, from the date the waiver is revoked.

10.6 Notice Requirements.

(a) Notice of Basic Rights. The Plan shall provide the Participant (and Spouse, if applicable) with initial notice of COBRA Continuation Coverage rights not later than ninety (90) days after the date on which such individual's Health Insurance Coverage under the Plan commences.

(b) Notice of Qualifying Event by Qualified Beneficiary. The affected Qualified Beneficiary shall notify the Benefits Administrator of the Qualifying Event within sixty (60) days after the later of the date of the Qualifying Event or the date Health Insurance Coverage would be lost. Such notice must include the name of the Plan, the name of the Participant, the name, address and phone number of the Qualified Beneficiary, a description of the Qualifying Event, and the date on which the Qualifying Event occurred. The Benefits Administrator shall then promptly notify the COBRA Administrator of the Qualifying Event.

(c) Notice of Right to Elect or Unavailability. Within fourteen (14) days after the Benefits Administrator receives notification of a Qualifying Event, the COBRA Administrator must notify each affected Qualified Beneficiary of his or her right to elect COBRA Continuation Coverage. Notification to a Spouse is treated as notification to the Spouse and all Dependent Children who reside with the Spouse at the time of the notification. In the event that the COBRA Administrator receives a notice under subsection (b) above and determines that such individual is not entitled to COBRA Continuation Coverage, the notice required under this subsection (c) shall explain why such individual is not entitled to COBRA Continuation Coverage.

(d) Notice of Early Termination. In the event that a Qualified Beneficiary's COBRA Continuation Coverage is terminated in accordance with Section 10.3(b), the COBRA Administrator shall promptly provide the Qualified Beneficiary with a termination notice.

(e) Notice of Conversion Option. With respect to a Qualified Beneficiary whose COBRA Continuation Coverage ends as a result of the expiration of the COBRA coverage period, the COBRA Administrator must notify the Qualified Beneficiary of the option of enrolling under any conversion health plan that may be available under Health Insurance Coverage prior to the expiration of such period.

(f) Dependent Child. The COBRA Administrator may provide notice to each Qualified Beneficiary who is the Dependent Child of a covered employee by furnishing a single notice to the Participant or the Participant's Spouse, if, on the basis of the most recent information available to the Plan, the Dependent Child resides at the same location as the individual to whom such notice is provided.

(g) Compliance with Regulations. Each notice provided under this Section 10.6 shall comply with the most recent, applicable guidance issued by the Department of Labor regarding the content of such notices.

10.7 Plan Sponsor Withdrawal.

Notwithstanding anything in this Article X to the contrary, in the event that the Plan Sponsor withdraws from the Emeriti Program, the Plan Sponsor shall be solely responsible for complying with the requirements of COBRA.

10.8 Plan Sponsor's Bankruptcy.

In the event that an Employer's filing of a proceeding in bankruptcy under Title 11 of the United States Code causes a loss of coverage or substantial elimination of coverage in the Emeriti Health Insurance Plan Options for any Participant, Spouse, or Dependent Child under the terms of the Plan, such individual shall become a Qualified Beneficiary and shall be entitled to COBRA Continuation Coverage in accordance with the provisions of COBRA and the applicable Treasury Regulations governing bankruptcy.

ARTICLE XI – COURT ORDERS

11.1 Domestic Relations Orders.

The Plan is not subject to Section 414(p) of the Internal Revenue Code. The rules described in this Section 11.1 shall apply to any domestic relations order received by the Plan Sponsor relating to the Participant's Account(s). The Plan Sponsor shall have the sole discretion to determine whether any domestic relations order satisfies the requirements of this Section 11.1.

(a) Content of Orders. Subject to the other requirements of this Section 11.1, the Plan Sponsor shall honor the terms of any domestic relations order that meets the following requirements:

(1) Such order is a judgment, decree, or order (including approval of a property settlement agreement) which: (i) relates to the provision of child support, alimony payments, or marital property rights to a Spouse, former Spouse, Dependent Child, or Dependent Relative ("alternate account holder") of a Participant; and (ii) is made pursuant to State domestic relations law (including a community property law).

(2) Such order identifies:

(i) the Plan by name;

(ii) one or more alternate account holders who are entitled to a portion of the Participant's Accounts; and

(iii) the name and last known mailing address (if any) of the Participant and the name and mailing address of each alternate account holder.

(3) Such order provides for the division of the balance in the Participant's Account(s) (not including any amount subject to forfeiture under Section 5.8 of the Plan), by amount or percentage, upon the occurrence of a specified date or event, at which time the alternate account holder's portion shall be transferred to a separate account (or otherwise segregated) for the benefit of the alternate account holder.

(4) Such order does not:

(i) require the Plan to provide any type of benefit, or any option, not otherwise provided under the Plan;

(ii) require the Plan to provide increased benefits; and

(iii) does not infringe upon the rights of another alternate account holder established under another order previously determined by the Plan Sponsor to be a domestic relations order meeting the requirements of this Section 11.1.

(5) Notwithstanding the foregoing requirements, the Plan Sponsor shall honor the terms of any domestic relations order as necessary to comply with applicable law.

(b) Limitation on Alternate Account Holder's Rights. Neither a Participant nor an alternate account holder may agree to a provision requiring the Plan to provide Health Insurance Coverage to the alternate account holder beyond the period required by COBRA. In addition:

(1) If the alternate account holder is also a Participant under the Plan, the alternate account holder's Account(s) shall be credited with the amount(s) stated under the order and thereafter such amount(s) shall be treated without distinction from other amounts held in the alternate account holder's Account(s).

(2) If the alternate account holder is not a Participant under the Plan, the alternate account holder shall be immediately and only entitled to Reimbursement Benefits paid from the alternate account holder's separate account. With respect to such Reimbursement Benefits, the alternate account holder shall be permitted to submit claims for reimbursement of Qualified Medical Expenses incurred by the alternate account holder and his or her Spouse (or Domestic Partner), Dependent Children, and/or Dependent Relatives. The alternate account holder shall not be entitled to make contributions to his or her Account(s).

(c) Effect of Alternate Account Holder's Death. If the alternate account holder is also a Participant under the Plan, the alternate account holder's Account(s) upon the alternate account holder's death shall be treated under the rules applicable to Participants. If the alternate account holder is not a Participant under the Plan, then upon the alternate account holder's death:

(1) the residual balance in his or her Employee After-Tax Contribution Account shall be transferred to the Participant's Employee After-Tax Contribution Account, unless there is no person remaining to utilize such Account upon the application of Section 5.7, in which case, the alternate account holder's Employee After-Tax Contribution Account shall be forfeited and treated in accordance with Sections 5.8 and 5.9; and

(2) the residual balance in his or her Employer-Contribution account shall be transferred to the Participant's Employer-Contribution Account, unless there is no person remaining to utilize such Account upon the application

of Section 5.7, in which case, the alternate account holder's Employer-Contribution Account shall be forfeited and treated in accordance with Sections 5.8 and 5.9.

(d) Procedure for Determinations. The Procedures for processing domestic relations orders are as follows:

(1) Pre-approval of Orders. If the Participant or potential alternate account holder submits a draft domestic relations order to the Plan Sponsor, the Plan Sponsor shall review the draft domestic relations order and advise the parties as to whether the domestic relations order, if entered by a court, would satisfy the requirements of this Section 11.1.

(2) Release of Information. Participant Account balances and other Account information shall be provided, to the extent reasonably available, to the Spouse or to any other party for whom the Participant has authorized release of the information. Any request for information, and any authorization for release of information, must be in writing and delivered to the Plan Sponsor.

(3) Hold Period. When the Plan Sponsor receives a copy of a draft domestic relations order, the Plan Sponsor shall promptly notify the Participant, potential alternate account holder, and the Record Keeper that a six (6)-month "hold" will be placed on the Participant's Reimbursement Benefits (but not Health Insurance Premium payments) under the Plan pending review and processing of a final domestic relations order. The Plan Sponsor shall include a copy of these domestic relations order procedures with the notification. The hold shall be removed upon the earliest of:

(i) the expiration of six (6) months from the date the draft domestic relations order was received;

(ii) the date that the Plan Sponsor is notified by both the Participant and potential alternate account holder that a final domestic relations order will not be submitted for review (each notification must be in writing and notarized); or

(iii) the date that the Plan Sponsor determines the approved status of the domestic relations order and the alternate account holder's interest is established under subsection (4) below.

(4) Review of Final Order. When the Participant or potential alternate account holder submits a copy of the final, signed domestic relations order for review, the Plan Sponsor shall notify the Record Keeper to place or extend a hold on the Participant's Reimbursement Benefits (but not Health Insurance Premium payments) pending review and processing of the

domestic relations order. If the review and processing of the domestic relations order will take longer than five (5) business days, the Plan Sponsor shall promptly notify the Participant and potential alternate account holder that the existing hold on the Participant's Reimbursement Benefits will continue or, if none currently exists, that a hold will be placed on the Participant's Reimbursement Benefits (but not Health Insurance Premium payments) pending review and processing of the domestic relations order (the Plan Sponsor shall notify the Record Keeper of such fact). The Plan Sponsor shall include a copy of these domestic relations order procedures with the notification, unless it has been previously provided. The Plan Sponsor shall then review the final, signed domestic relations order to determine whether it meets the requirements of this Section 11.1. Once a hold has been placed upon the Participant's Reimbursement Benefits under this subsection (4) or a hold established under subsection (3) has been extended, the hold shall be removed upon the earliest of:

(i) the date that the Plan Sponsor determines the qualified status of the domestic relations order and the alternate account holder's interest is established; or

(ii) upon the expiration of six (6) months from the later of the date the hold was established or extended.

(5) Notification of Adverse Determination. If the final, signed domestic relations order is found not to meet the requirements of this Section 11.1, the Plan Sponsor shall notify the Participant and potential alternate account holder (and their legal counsel, if known) of its determination, indicating the reasons why it is unacceptable (and will include a copy of these procedures if the individual has not previously received a copy).

(6) Establishment of Segregated Account(s). If the final, signed domestic relations order is found to meet the requirements of this Section 11.1, the Plan Sponsor shall notify the Participant, alternate account holder (and their legal counsel, if known), and the Record Keeper of its determination, indicating that the Participant's Account(s) under the Plan will be divided and the alternate account holder's portion transferred to a separate Account(s) established or otherwise segregated for the alternate account holder. The alternate account holder shall be mailed a notice of the transfer or segregation explaining his or her rights with regards to the Account(s) or segregated portion of any Account. The Participant shall have no rights with respect to the alternate account holder's Account(s) or segregated portion of any Account. To execute the order, the Participant's Account(s) shall be divided pro-rata among the Mutual Funds of the Account(s), unless specifically directed otherwise in the domestic relations order in a manner that can reasonably be executed by the Record Keeper.

The alternate account holder shall have the right to direct the investment of his or her Account(s), or segregated portion of any Account in accordance with Article IV (INVESTMENT OF ACCOUNTS).

11.2 Qualified Medical Child Support Orders.

The Plan shall comply with the requirements of a qualified medical child support order pursuant to Section 609 of ERISA. The Plan Sponsor shall have the sole discretion to determine whether medical child support orders are qualified medical child support orders and to direct the provision of benefits under such qualified orders:

(a) Notice on Receipt of Order. When a medical child support order is received, the Plan Sponsor shall promptly notify the Participant named in the order and any alternate recipient named in the order that:

(1) a medical child support order has been received;

(2) the Plan Sponsor will make a determination of the qualified status of the order;

(3) the Participant or the alternate recipient may submit to the Plan Sponsor any information to be considered as to the order of qualification within thirty (30) days of the notice;

(4) the Plan Sponsor may require the Participant or the alternate recipient to submit additional information that the Plan Sponsor deems necessary or appropriate to make a determination;

(5) the alternate recipient may designate a representative for receipt of notices; and

(6) the Plan Sponsor shall notify the Participant and the alternate recipient of the determination and the reasons for any determination that the order is not a qualified medical child support order.

With respect to a medical child support order received which pertains to a Participant who is not yet eligible for medical benefits under Article VI (HEALTH INSURANCE COVERAGE) or Article VII (REIMBURSEMENT BENEFITS), the Plan Sponsor shall promptly notify the Participant named in the order and any alternate recipient named in the order that the order is not a qualified medical child support order, because the Participant is not yet eligible for benefits, and the Plan does not provide benefits for Dependent Children of Participants who are not yet eligible for benefits. If the Participant is expected to become eligible at a later date, such notice shall include an estimate of when the Participant may become eligible.

(b) Determination Process. The Plan Sponsor shall request from the Participant or the alternate recipient any additional information that the Plan Sponsor deems necessary or appropriate to make a determination. Any additional information shall be provided within thirty (30) days of request, unless an extension of time is granted by the Plan Sponsor.

(c) Timing for and Notice of Determination.

(1) The Plan Sponsor shall make a determination about the qualification of the order as soon as practicable. The determination shall be made within ninety (90) days after receipt of the order, unless the Plan Sponsor determines that additional time is required. The Plan Sponsor shall notify the Participant and the alternate recipient of the determination of the qualified status of the order. If the order is determined not to be qualified, the notice shall provide the reason for the determination. The notice shall advise the Participant and the alternate recipient of the right to appeal the determination under the procedures in Article IX (CLAIMS PROCEDURES) of this Plan.

(2) Notwithstanding subsection (1) above, with respect to any properly completed National Medical Support Notice (under Section 401(b) of the Child Support Performance and Incentive Act of 1998) issued in the case of a child of a Participant who is a non-custodial parent of the child, if the notice meets the requirements of a qualified medical child support order, the Plan Sponsor shall:

(i) notify the State agency issuing the notice whether coverage of the child is available under the terms of the Plan and, if so, whether such child is covered under the Plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the official of a State or political subdivision thereof substituted for the name of such child) to effectuate the coverage; and

(ii) provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

Such notice shall be provided within twenty (20) business days of the date of the notice if the Participant is not eligible for coverage, and otherwise within forty (40) business days of the date of the notice.

(d) Enrollment. After the Plan Sponsor determines that an order is a qualified medical child support order, the following provisions shall apply:

(1) The Plan Sponsor shall notify the Record Keeper of the effect of the order.

(2) The alternate recipient shall be considered a Dependent Child for purposes of receiving Reimbursement Benefits and Health Insurance Benefits under the Plan. The alternate recipient shall be eligible to enroll in Health Insurance Coverage only if the Participant is enrolled in Health Insurance Coverage or was eligible for Health Insurance Coverage but waived coverage (the Participant must enroll). The alternate recipient shall have the right to submit claims for Reimbursement Benefits independent of the Participant.

(3) Reimbursement Benefits and Health Insurance Benefits, when not payable directly to a provider, shall be paid to the alternate recipient or the alternate recipient's custodial parent.

(e) Definitions. The following definitions shall apply for purposes of this Plan:

(1) "Medical child support order" means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which: (i) provides for child support with respect to a child of a Participant under this Plan or provides for health benefits coverage to such a child, is made pursuant to a State domestic relations law (including a community property law), and relates to benefits under this Plan; or (ii) enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to this Plan.

(2) "Alternate recipient" means any child of a Participant who is recognized under a medical child support order as having a right to enrollment under this Plan with respect to such Participant.

(3) "Qualified medical child support order" means a medical child support order that:

(i) creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a Participant is eligible under this Plan;

(ii) clearly specifies the name and the last known mailing address (if any) of the Participant and the name and mailing address of each alternate recipient covered by the order (or provides the name and mailing address of an official of a State or a political subdivision thereof who is substituted for the alternate recipient);

(iii) provides a reasonable description of the type of coverage to be provided by the Plan to each such alternate recipient, or the manner in which such type of coverage is to be determined;

(iv) clearly specifies the period to which such order applies under this Plan; and

(v) does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act. An order shall not be treated as a qualified medical child support order under this Plan if it pertains to a Participant who is not yet eligible for medical benefits under Articles VI and VII.

ARTICLE XII – AMENDMENT AND TERMINATION

12.1 Amendment.

The Plan Sponsor shall have the right to modify, alter, or amend the Plan or the Trusts in whole or in part; provided, however, that during the term of the Membership Contract the Plan Sponsor may do so only with the consent of Emeriti and, with respect to the Trusts, the Trustee, and no such modification, alteration, or amendment:

(a) may change the powers, responsibilities, or liabilities of the Record Keeper, the Health Insurer, or the Trustee without such party's written consent; or

(b) shall have the effect of returning to the Employer any part of the principal or income of the Trusts.

Any attempt by the Plan Sponsor to modify, alter, or amend the Plan or the Trusts without the consent of Emeriti shall constitute notice to Emeriti of the Plan Sponsor's intent to terminate the Membership Contract and withdraw from the Emeriti Program.

Any right of a Participant, Spouse (or Domestic Partner), or Dependent Child to Health Insurance Coverage, Health Insurance Plan Options, and/or Health Insurance Benefits under the Plan shall at all times remain subject to the Plan Sponsor's right under the Plan and Emeriti's right under the Emeriti Program to amend, modify, or terminate Health Insurance Coverage, Health Insurance Plan Options, and/or Health Insurance Benefits under the Plan or Emeriti Program, as applicable.

Subject to the foregoing provisions, the Schedules in the Adoption Agreement may be amended without the need to execute a new Adoption Agreement. Such amendment shall be made by the Plan Sponsor providing Emeriti with a copy of the Schedule as amended along with a written certification, subject any requirements of Emeriti, specifying that the Plan is amended by substituting the amended Schedule.

12.2 Withdrawal from Emeriti Program.

In the event that the Plan Sponsor withdraws from the Emeriti Program by failing to renew or terminating the Membership Contract, the Plan Sponsor may continue this Plan outside of the Emeriti Program; provided, however, that upon expiration or termination of the Membership Contract:

(a) all references in the Plan to Emeriti and the Emeriti Program, shall be immediately and automatically stricken from the Plan, and the Plan Sponsor shall be required to amend or restate the Plan if it desires to continue the Plan; and

(b) Emeriti, the Record Keeper, the Health Insurer, and the Benefits Administrator shall have no obligation to the Employer, the Plan, Participants, Spouses, Domestic Partners, Dependent Children, Dependent Relatives, and Beneficiaries,

except as expressly provided in the Membership Contract or other agreement between Emeriti, the Record Keeper, the Health Insurer and/or Benefits Administrator and the Plan Sponsor.

12.3 Termination.

Subject to the terms of the Membership Contract and any notice required by the Record Keeper, Health Insurer, Reimbursement Processor, and Trustee, with respect to Participants the Plan Sponsor reserves the right to discontinue contributions, eliminate any form of benefit, or terminate this Plan at any time.

ARTICLE XIII – HEALTH PRIVACY

13.1 Definitions.

For purposes of this Article XIII, the following terms shall have the following meanings. Any term that is not defined below, but which has an assigned meaning under the Privacy Rule, shall have that assigned meaning for purposes of this Article XIII.

(a) "Electronic Protected Health Information" means Protected Health Information that is transmitted or maintained in electronic media.

(b) "Individually Identifiable Health Information" means health information, including demographic information, collected from an individual and which:

(i) is created or received by a health care provider, health plan (including this Plan), employer (including the Employer), or health care clearinghouse, and

(ii) 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

(iii) which identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

(c) "Plan Administration Functions" means administrative functions performed by the Employer on behalf of the Plan, but excluding any functions performed by the Employer in connection with any other benefit or employee benefit plan of the Employer.

(d) "Privacy Rule" shall mean the regulations promulgated by the U.S. Department of Health and Human Services pursuant to Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996, and which are contained in 45 Code of Federal Regulations, Parts 160 and 164, Subpart E.

(e) "Protected Health Information" means Individually Identifiable Health Information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or media, but excludes employment records held by, or on behalf of, the Employer.

(f) "Security Rule" shall mean the regulations promulgated by the U.S. Department of Health and Human Services pursuant to Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996, and which are contained in 45 Code of Federal Regulations, Parts 160 and 164, Subpart C.

(g) "Summary Health Information" means information, which may be Individually Identifiable Health Information, that:

(i) summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan (including the Plan), and

(ii) from which certain specified information has been deleted, as required under the Privacy Rule.

13.2 Summary Health Information, Information Regarding Participation and Enrollment, and Aggregate Data.

The Plan shall disclose Summary Health Information to the Employer if the Employer requests to receive such Summary Health Information for purposes of (1) obtaining premium bids for providing Health Insurance Coverage under the Plan, or (2) modifying, amending or terminating the Plan. The Plan shall, to the extent permitted by the Plan's notice of privacy practices, disclose to the Employer, upon request, information concerning whether an individual is participating in the Plan, or is enrolled in or has disenrolled from Health Insurance Coverage offered under the Plan. The Plan may disclose aggregate data reports to the Employer, provided such reports do not include Individually Identifiable Health Information and do not summarize the claims history, claims expenses, or type of claims experienced by specific individuals.

13.3 Authorizations and Disclosures Required by Law.

The Plan may disclose Protected Health Information to the Employer for purposes other than Plan Administration Functions pursuant to a valid authorization received from the individual who is the subject of the Protected Health Information, or if the disclosure is otherwise required pursuant to applicable law.

13.4 Protected Health Information.

Subject to the provisions of Sections 13.6 and 13.7, the Plan shall, at the request of the Employer or as required under the terms of the Plan, disclose Protected Health Information to the Employer solely to enable the Employer to perform Plan Administration Functions. Such functions shall include those Plan Administration Functions necessary to carry out the Plan's treatment, payment, and health care operations as those terms are defined under the Privacy Rule. The Plan may disclose Protected Health Information to Emeriti, as a Business Associate of the Plan, necessary for Emeriti to fulfill its administrative duties under the Plan.

13.5 Restrictions on the Employer's Uses and Disclosures of Protected Health Information.

The Employer shall be subject to certain restrictions with respect to the Protected Health Information that the Employer receives from the Plan. The Employer shall:

(a) Not use or further disclose the information other than as described in this Article XIII, or as required by law.

(b) Ensure that any agents (including a subcontractor) to whom the Employer provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information.

(c) Not use or disclose the Protected Health Information for employment related actions and decisions or in connection with any other benefit or employee benefit plans of the Employer, unless authorized by the individual who is the subject of the Protected Health Information.

(d) Report to the Plan any use or disclosure of the Protected Health Information that is inconsistent with the uses or disclosures described in this Article XIII of which the Employer becomes aware.

(e) As required by the Privacy Rule:

  (i) Make Protected Health Information available to individuals, including for purposes of amendment of their Protected Health Information,

  (ii) Incorporate any such amendments, and

  (iii) Make available the information required to provide individuals with an accounting of certain of the Employer's disclosures of their Protected Health Information.

(f) Make internal practices, books and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule.

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

(h) Ensure that there is adequate separation between the Employer and the Plan in accordance with the provisions set forth below and in accordance with the Privacy Rule.

(i) Not disclose Individually Identifiable Health Information to Emeriti.

13.6 Requirements for the Plan.

The Plan shall be subject to the following requirements when disclosing information to the Employer:

(a) The Plan shall disclose Protected Health Information to the Employer only if the Plan has received written certification from the Plan Sponsor that the Plan Sponsor has adopted this Article XIII and agreed (on behalf of itself and each Participating Affiliate) to the provisions set forth in Section 13.5 (such certification is provided in the Adoption Agreement.

(b) The Plan shall not permit a Health Insurer with respect to the Plan to disclose Protected Health Information to the Employer, except as otherwise provided by this Article XIII.

(c) The Plan shall not disclose and shall not permit a Health Insurer to disclose Protected Health Information to the Employer, unless the notice of privacy practices issued by the Plan permits such disclosure.

(d) The Plan shall not disclose Protected Health Information to the Employer for employment-related actions or decisions or in connection with any other benefit or employee benefit plans of the Employer, unless authorized by the individual who is the subject of the Protected Health Information.

13.7 Employees of the Employer and other Work Force Members Eligible to Receive Protected Health Information.

The Protected Health Information disclosed to the Employer pursuant to Section 13.4 may only be disclosed to and used by the Employer's privacy officer, Employees responsible for administration of this Plan, the senior benefits officer, the members of the committee (including any third party reviewer appointed under Section 9.7) that makes benefits determinations on appeals under this Plan, and attorneys in the Employer's legal department. Such individuals shall have access to protected health information solely to perform Plan Administration Functions. The Plan Sponsor shall provide written notice to the Plan of any other individuals who may receive Protected Health Information from the Plan.

13.8 Procedures for Handling Noncompliance with the Privacy Rule.

In the event that a person described in Section 13.7 uses or discloses Protected Health Information in a manner that is not permitted by the Privacy Rule, as described in this Article XIII, the Employer shall resolve any such instances of non-compliance in accordance with the Employer's Privacy Rule policies and procedures. If the Employer learns of a violation of the Privacy Rules, it will take reasonable steps to mitigate the harmful effect of the improper use or disclosure of protected health information.

13.9 Security of Electronic Protected Health Information.

Except when the only Electronic Protected Health Information disclosed to the Employer is disclosed pursuant to 45 CFR 164.504(f)(1)(ii) or (iii), or as authorized under 45 CRF 164.508, the Employer shall reasonably and appropriately safeguard Electronic Protected Health Information created, received, maintained or transmitted on behalf of the Plan as required by the Security Rule. Specifically, the Company shall:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Ensure that the adequate separation required by 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

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

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

13.10 Purpose and Construction.

The foregoing provisions of this Article XII are designed to comply with Section 164.504(f) of the Privacy Rule and Section 164.314(b)(2) of the Security Rule and shall be construed and interpreted in accordance with those regulations. This Article XIII is not is not intended and shall not be construed to establish any rights with respect to Plan Participants or their dependents and beneficiaries, other than those rights that they may have under the Privacy Rule and Security Rule.

ARTICLE XIV – TRUSTS

14.1 Establishment of Trusts.

All of the assets of the Plan shall be held in the Trusts, which shall each be established in accordance with the Trust Agreements.

14.2 Appointment of Trustee.

The Trusts shall be held by the Trustee. Upon execution of the Adoption Agreement, the Trustee shall have the exclusive responsibility and authority to hold and invest the assets of the Plan, as provided in the Plan and the Trust Agreements. Emeriti shall have no authority to direct the Trustee to disburse any amounts from the Trusts, whether in the form of benefits, premiums, fees, or otherwise.

14.3 Removal of Trustee.

Removal of the Trustee shall be governed by the Trust Agreements. In the event that the Plan Sponsor removes the Trustee under either Trust without the consent of Emeriti, such removal shall constitute notice to Emeriti of the Plan Sponsor's intent to terminate the Membership Contract and withdraw from the Emeriti Program.

14.4 Amendment of Trust Agreements.

Amendment of the Trust Agreements shall be governed by the Trust Agreements. In the event that the Plan Sponsor amends either Trust Agreement without the consent of Emeriti, such amendment shall constitute notice to Emeriti of the Plan Sponsor's intent to terminate the Membership Contract and withdraw from the Emeriti Program.

14.5 Withdrawal From Emeriti Program.

In the event that the Plan Sponsor withdraws from the Emeriti Program, the Plan Sponsor shall be solely responsible for directing the Trustee with respect to any funds remaining in the Employer-Contribution Account and Employee After-Tax Contribution Account.

ARTICLE XV – GENERAL PROVISIONS

15.1 Entire Agreement.

This Plan shall constitute the entire agreement with respect to the benefits described herein.

15.2 No Other Benefits.

This Plan shall provide no benefits other than the medical benefits provided under Articles VI and VII.

15.3 Limitation of Rights.

The Plan is maintained exclusively for the benefit of Participants, Spouses, Domestic Partners, Dependent Children, and Dependent Relatives. It is the intention of the Plan Sponsor to continue the Plan for an indefinite period of time. All of the rights offered the Participants hereunder are legally enforceable. Neither the establishment of the Plan, nor any amendment thereof, nor the payment of any benefits, shall be construed as giving to any Participant or other person any legal or equitable right against the Employer, Emeriti, or their delegates, except as provided herein. The foregoing shall not in any way limit any individual's rights which may be available under federal or state securities laws.

15.4 Nonalienation of Benefits.

No person shall have any interest in or right to any assets of the Trusts or any rights under the Plan except to the extent expressly provided in the Plan or as otherwise required by law. Subject to applicable law, benefits payable under the Plan shall not be includible in the Participant's bankruptcy estate nor subject in any manner to bankruptcy, anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any liability for alimony or other payments for the support of a spouse, former spouse, or for any other relative of a Participant, dependent, or beneficiary, before actually being received by the person entitled thereto under the terms of the Plan except pursuant to a court order described in Article XI (COURT ORDERS) or any judgment, decree, order or settlement similar to one permitted under Section 401(a)(13)(C) of the Internal Revenue Code. Subject to applicable law, any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable under the Plan shall be void. The Trusts shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, or torts of any person entitled to benefits hereunder.

15.5 No Contract of Employment.

Nothing contained in the Plan shall be construed as a contract of employment between the Employer and any person, or as giving a right to any person to continue in the

employment of the Employer, or as limiting the right of the Employer to discharge any person at any time, with or without cause.

15.6 Non-Reversion.

No funds held in the Trusts shall revert to the Employer or be used for any purpose other than for the exclusive benefit of Participants, Spouses, Domestic Partners, Dependent Children, and Dependent Relatives except as expressly provided herein.

15.7 Delegation of Authority.

Whenever the Plan Sponsor or the Employer is permitted or required to perform any act, such act may be performed by any officer or other person duly authorized by Plan Sponsor or the Employer, as applicable.

15.8 Compliance With Applicable Law.

(a) This Plan and all rights hereunder shall be governed, construed, administered, and enforced according to ERISA, the Internal Revenue Code and any other applicable Federal law, except if the Plan is established by a Governmental Entity, in which case ERISA shall not apply. The Plan Sponsor has executed an irrevocable election under Section 410(d) of the Internal Revenue Code, limited to this Plan, as a condition of participation in the Emeriti Program.

(b) Unless otherwise indicated in the Plan, the Health Insurer shall be solely responsible for ensuring that Health Insurance Coverage, Health Insurance Plan Options, and Health Insurance Benefits comply with the following Federal laws:

(i) Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA);

(ii) Mental Health Parity Act of 1996 (MHPA);

(iii) Newborns' and Mothers' Health Protection Act of 1996 (NMHPA);

(iv) Women's Health and Cancer Rights Act of 1998 (WHCRA);

(v) Uniform Services Employment and Reemployment Rights Act (USERRA);

(vi) Genetic Information Nondiscrimination Act of 2008 (GINA);

(vii) Michelle's Law (Section 2728 of the PHSA and Section 9813 of the Internal Revenue Code and Section 714 of ERISA; and

(viii) Patient Protection and Affordable Care Act of 2009 (PPACA).

(c) Notwithstanding the foregoing, to the extent not preempted by ERISA or any other applicable Federal law, this Plan and all rights hereunder shall be governed, construed, administered, and enforced according to the laws of the State in which the Plan Sponsor has its principal place of operation.

15.9 Construction and Severability.

Each provision of the Plan shall be considered to be severable from all other provisions, so that if any provision or any part of a provision shall be declared void, the remaining provisions shall continue to be effective.

15.10 Gender and Number.

Every pronoun used in the Plan shall be construed to be of such number and gender as the context shall require.

APPENDIX A – SPECIAL RULES APPLICABLE TO THE HEALTH INSURANCE PLAN OPTIONS

This Appendix A, which is considered part of the Plan, describes certain specific terms and conditions related to the Health Insurance Plan Options offered under the Plan.

1. **Minnesota Employers:** In the event that the Employer is located in Minnesota ("MN"):

   (a) Any Participant and any Spouse (or Domestic Partner) who permanently resides in MN and is eligible for coverage under the Health Insurance Plan Options shall receive such coverage through Health Partners; provided, however, that an Aetna RX only Health Insurance Plan Option may be made available to such individuals.

   (b) Any Participant and any Spouse (or Domestic Partner) who permanently resides outside of MN and is eligible for coverage under the Health Insurance Plan Options shall receive such coverage through Aetna.

   (c) In the event that the Participant permanently resides in MN and the Participant's Spouse (or Domestic Partner) permanently resides elsewhere, the Spouse (or Domestic Partner) shall not be required to enroll in the same Health Insurance Plan Option as the Participant. The same rule will apply if the Participant permanently resides outside of MN and the Participant's Spouse (or Domestic Partner) permanently resides in MN.

2. **Spouse (or Domestic Partner) Coverage Outside of Minnesota or New Mexico:** In the event that the Employer is located outside of MN or New Mexico, any Participant and any Spouse (or Domestic Partner) who is eligible for coverage under the Health Insurance Plan Options shall receive such coverage through Aetna regardless of his or her state of residence.

3. **Dependents:** In the event that a Dependent Child is eligible for coverage under the Health Insurance Plan Options, he or she will receive such coverage through the same Health Insurer as the Participant (except to the extent required in order to comply with a qualified medical child support order).

4. **Special Enrollment Rights in Minnesota:** With respect to any Participant who resides in MN, if such Participant is enrolled in a Health Insurance Plan Option and is eligible to enroll a new Dependent Child under Section 6.5 of the Plan, the requirement to enroll such Dependent Child within thirty (30) days of the special enrollment event shall not apply.

5. **Transfer Between Options:** An enrolled Participant or other enrolled individual who moves to a State or coverage area may make a mid-year change to a different Health Insurance Plan Option if the Health Insurance Plan Options for that State or coverage

area are different than those available in the State or coverage area from which he or she moved (subject to the other rules of the Plan regarding enrollment in the Health Insurance Plan Options). Application of Medicare rules may result in a temporary lapse in Health Insurance Coverage if a Participant or other enrolled individual changes residence (e.g., from one State to another or between coverage areas).

6. **Transfer Between Insurers:** If an enrolled Participant or other enrolled individual moves to a State or area covered by a different Health Insurer, he or she may select from any of the Health Insurance Plan Options offered by such Health Insurer for which he or she is eligible without regard to the prior Health Insurance Plan Option in which he or she was enrolled; provided he or she does so within thirty (30) days of moving to the new State or coverage area.

7. **Enrollment in Non-Emeriti Part D Plans:** If a Medicare-eligible individual is enrolled in a Post-65 Health Insurance Plan Option that provides prescription drug coverage and his or her enrollment is cancelled due to subsequent enrollment in a Medicare Part D plan offered outside of the Plan, there is no guarantee that a Post-65 Health Insurance Plan Option without prescription drug coverage will be available under the Plan or that reenrollment will be permitted at a later date.

8. **Participants Who Are Spouses (or Domestic Partners) of Each Other:** With respect to Participants who are Spouses of each other (or are Domestic Partners of each other) (referred to below as "Participant 1" and "Participant 2"), the following rules shall apply when each is eligible to enroll in the Health Insurance Plan Options:

   (a) If Participant 1 is eligible for the Post-65 Health Insurance Plan Options and Participant 2 is not, then Participant 2 can be enrolled as the "Spouse (or Domestic Partner)" of Participant 1 in a Pre-65 Health Insurance Plan Option, irrespective of whether Pre-65 Health Insurance Options are available to Participants under the Adoption Agreement. If Participant 2 later becomes eligible for the Post-65 Health Insurance Plan Options, Participant 2 may elect to remain enrolled as the "Spouse (or Domestic Partner)", in which case all Health Insurance Premiums will continue to be paid from Participant 1's Accounts. If Participant 1's Accounts are later exhausted, and Participant 2 has a positive balance in his or her Accounts, they may elect to reenroll with Participant 2 listed as the "Participant" and Participant 1 listed as the "Spouse (or Domestic Partner)," but they cannot use the event to change Post-65 Health Insurance Plan Options. In that case, all Health Insurance Premiums will be paid from Participant 2's Accounts.

   (b) If Participants 1 and 2 are both eligible for the Post-65 Health Insurance Plan Options:

      (i) They may elect to each enroll in separate Post-65 Health Insurance Plan Options as "Participants." In that case, Health Insurance Premiums for Participant 1 will be paid from Participant 1's Accounts, and Health

Insurance Premiums for Participant 2 will be paid from Participant 2's Accounts. If Participant 1's Accounts are later exhausted, and Participant 2 has a positive balance in his or her Accounts, they may elect to reenroll with Participant 2 listed as the "Participant" and Participant 1 listed as the "Spouse (or Domestic Partner)" in which case all Health Insurance Premiums will be paid from Participant 2's Accounts; or

(ii) They may elect to enroll with Participant 1 listed as the "Participant" and Participant 2 listed as the "Spouse (or Domestic Partner)." In that case, all Health Insurance Premiums will be paid from Participant 1's Accounts. If Participant 1's Accounts are later exhausted, and Participant 2 has a positive balance in his or her Accounts, they may elect to reenroll with Participant 2 listed as the "Participant" and Participant 1 listed as the "Spouse (or Domestic Partner)," but they cannot use the event to change Post- 65 Health Insurance Plan Options. In that case, all Health Insurance Premiums will be paid from Participant 2's Accounts.