BIRMINGHAM-SOUTHERN COLLEGE WELFARE BENEFITS PLAN

Plan Document
And
Summary Plan Description

Amended and Restated as of January 1, 2018

TABLE OF CONTENTS

ARTICLE I

INTRODUCTION

Birmingham Southern College (the "***College***") sponsors and maintains the Birmingham Southern College Welfare Benefits Plan (the "***Plan***"). The Plan is an ERISA employee welfare plan providing health and welfare benefits for the exclusive benefit of the College's eligible employees and their eligible family members.

The Plan provides health and welfare benefits through the following component benefit programs:

- Medical PPO Plan benefit programs (including prescription drug benefit)
- Medical High Deductible Health Plan with Health Savings Account benefit programs (including prescription drug benefit)
- Dental benefit program
- Vision benefit program
- Long term disability benefit program
- Life insurance and accidental death & disability benefit (including voluntary life and AD&D)
- Flexible spending and limited flexible spending components of the Birmingham Southern Cafeteria Plan

Each component benefit program has its own requirements for eligibility and enrollment. The component benefit programs are more fully described in the Attachments, which are incorporated by reference into the Plan.

This Plan document, together with the Attachments, is the plan document as well as the summary plan description ("***SPD***") for ERISA purposes. Except where otherwise expressly provided in the Plan or as necessary to comply with the law, in the event of any inconsistency between the Plan and the Attachments, the Plan's provisions shall control. The Plan, including its component benefit programs, is intended to be one plan, program or arrangement under ERISA and is treated as one plan for filing purposes.

ARTICLE II

DEFINITIONS

"**Affordable Care Act**" means the Patient Protection and Affordable Care Act, as amended.

"**Attachment**" means the evidence of coverage ("EOC"), insurance certificate booklets, and other Plan documents and summaries included in the sections titled "Attachment." These documents are hereby incorporated by reference and made a part of this Plan document and SPD.

"**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"**Code**" means the Internal Revenue Code of 1986, as amended.

"**Covered Entity**" means a health plan, a health care clearinghouse, or a health care provider that transmits any health information in electronic form in connection with a transaction covered by Subchapter A of 45 C.F.R. Subtitle A.

"**Dependent**" means a Participant's Spouse and any individual who qualifies as a Participant's dependent under the terms of any component benefit program. Notwithstanding anything to the contrary, a dependent for purposes of the medical program is eligible for medical coverage until age twenty-six (26) regardless of whether the dependent is married, or meets student status, residency (except for purposes of United States residency) or financial dependency requirements.

"**Employee**" means any person who is on the Employer's payroll. Employee does not mean any of the following:

(a) a self-employed individual, as defined in Code Section 401(c)(1)(A);

(b) a person the Plan Administrator determines is an independent contractor, a temporary employee, or a seasonal employee;

(c) employees in an employee unit covered by a collective bargaining unit agreement between Employee representatives and one or more Employers if this Plan's benefits were the subject of good faith bargaining between the Employee representatives and the Employer, unless such agreement provides for coverage for such bargaining employees in the Plan;

(d) leased employees, including but not limited to those individuals defined in Code Section 414(n);

(e) nonresident aliens who receive no earned income (within the meaning of Code Section 911(d)(2)) from an Employer that constitutes income from sources within the United States (as defined in Code Section 861(a)(3)); and

(f) any other individual who is not classified by the Employer as an Employee. The determination of whether an individual is an Employee under this Plan will be made solely in accordance with classifications used by the Employer regardless of the classification of such individual for any other purpose or any determination made by a court or government agency.

Any person the Plan Administrator determines is not an "Employee" as defined above shall not be eligible to participate in the Plan regardless of whether such determination is upheld by a court or tax or regulatory authority having jurisdiction over such matters. However, a person an Employer of the Plan Administrator determines is not an "Employee" as defined above and who later is required to be reclassified as an Employee shall be eligible to participate on a prospective basis only in the component benefit programs, provided that the individual is otherwise eligible pursuant to the terms of the applicable Attachment.

"**Employer**" means Birmingham Southern College.

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

"**FMLA**" means the Family and Medical Leave Act of 1993.

"**Group Health Plan**" means a component benefit program that is an employee welfare benefit plan, to the extent that the component benefit program provides medical care (as defined in Section 733(a)(2) of ERISA) to Participants or their Dependents directly or through insurance, reimbursement or otherwise.

"**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"**Participant**" means an Employee who has met the eligibility provisions of one or more component benefit programs and who has enrolled in accordance with such procedures as determined by the Plan Administrator. A Participant also may be referred to as a Member, Subscriber, or Insured in any particular component benefit program.

"**PHI**" or "**Protected Health Information**" means information collected from an individual and genetic information, whether oral or recorded, that (1) is maintained or transmitted in any form or medium, including electronic media; (2) is created or received by the Plan; (3) relates to the past, present, or future physical or mental health condition of a Participant, the provision of health care to a Participant, or the past, present, or future payment for health care; and (4) that identifies the Participant or for which there is a reasonable basis to believe the PHI can be used to identify the Participant.

"**Plan**" means this Birmingham Southern College Welfare Benefits Plan.

"**Plan Administrator**" means Birmingham Southern College.

"**Plan Sponsor**" means Birmingham Southern College.

"**Plan Year**" means the 12 month period beginning on January 1 and ending on the following December 31.

"**QMCSO**" means a qualified medical child support order, as defined in Section 609(a) of ERISA.

"**Rescission**" or "**Rescinded**" means the retroactive cancellation of coverage under a Group Health Plan for reasons other than: (1) the failure to pay required premiums; or (2) such other reasons as may be set forth in applicable guidance, such as retroactive cancellation due to reconciling lists of eligible employees and retroactive cancellation due to failure to notify the Plan Administrator in the event of divorce.

"**Spouse**" means an individual to whom a Participant is legally married.

"**USERRA**" means the Uniformed Services Employment and Reemployment Rights Act of 1994.

ARTICLE III

ELIGIBILITY AND ENROLLMENT

Eligibility

Employees and their Dependents are eligible to participate in the Plan if they satisfy the eligibility requirements of any one or more of the component benefit programs described in the Attachments. The Plan Administrator's determination of eligibility under the terms of the Plan shall be final and conclusive.

If an Employee is eligible for these benefits and properly elects to participate, the eligible Employee's "***Entry Date***" (or the date that coverage under these benefits begins) is the first day of the month coincident with or next following the date of hire.

The Plan Administrator shall, on or before the date on which the eligible Employee can begin participation in the Plan, give each eligible Employee notice of the Employee's eligibility to participate and of the requirements for electing to participate in any component benefit program.

Initial Enrollment

An Employee may first elect to participate in the Plan after meeting one (or more) component benefit program's eligibility criteria. This is called the "***initial enrollment period***." Component benefit program elections must be made in accordance with the terms and conditions established for that component benefit program by the Plan Administrator. An eligible Employee must supply such information as the Plan Administrator may require and, if the cost of the component benefit program is not fully paid by the Employer, shall be required to share the cost of the component benefit program as provided in the applicable Attachment.

Annual Enrollment

If an eligible Employee does not enroll within the employee's initial enrollment period described above, or would like to make changes in the coverage previously selected, the eligible Employee may make changes during an annual enrollment period. Employees will be notified prior to the start of each Plan Year when the Plan Year's annual enrollment period will open and close. Annual enrollment elections will take effect on the first day of the Plan Year immediately following the annual enrollment period (e.g., January 1).

Special Enrollment Rights

An eligible Employee who declined coverage during his initial enrollment period or an annual enrollment period may later enroll himself and/or his Dependents in any component benefit program that is a Group Health Plan if: (1) the individual seeking enrollment declined coverage under the component benefit program because he had coverage in another group health plan and coverage under the other group health plan was subsequently lost; (2) since declining coverage, the Employee has acquired a new Dependent (through marriage, birth, adoption, or placement for adoption); or (3) the individual seeking enrollment becomes eligible for a premium assistance subsidy for, or loses eligibility under, a Medicaid plan under Title XIX of the Social Security Act or under a state child health insurance plan. Enrollment must be requested within thirty (30) days of the event that gives rise to the special enrollment right if the event is described in (1) or (2) of the previous sentence; enrollment must be requested within sixty (60) days of the event that gives rise to the special enrollment right if the event is described in (3) of the previous sentence.

Qualified Medical Child Support Orders ("QMCSOs")

An eligible Employee's non-custodial child may be eligible to receive Group Health Plan benefits under a QMCSO. The Plan has procedures for determining whether an order qualifies as a QMCSO.

Termination of Participation

A Participant or Dependent shall cease participation in the Plan on the earliest to occur of the following events:

1. The Plan or a component benefit program is terminated;
2. The Participant or Dependent ceases to meet eligibility requirements;
3. The Participant's or Dependent's death;
4. The Participant's termination of employment with the College;
5. The Participant or Dependent requests to cease participation, either during an annual enrollment period or due to certain qualifying status changes; or
6. The Participant fails to timely pay required premiums.

Notwithstanding the foregoing, with respect to the dental benefits, in the event you terminate employment, coverage ends on the last day of the month in which you terminate employment. With respect to medical component benefits, coverage may also terminate if you commit fraud or intentionally misrepresent a material fact with respect to your coverage. In certain circumstances, such as layoff or leave, your coverage may continue, notwithstanding the occurrence of one of the termination events listed above. Please review the terms of the appropriate Attachment for more information.

If your coverage is Rescinded, you will receive at least thirty (30) calendar days advance notice. In some instances, you may be able to convert your coverage to an individual policy of insurance. Please refer to the appropriate Attachment for more information.

If a Participant or Dependent experiences a loss of coverage under a Group Health Plan, the Participant or Dependent may be eligible for rights under COBRA. See the "*Continuation Coverage Rights under COBRA*" section below.

ARTICLE IV

BENEFITS

Each component benefit program may offer a selection of benefits and coverage options from which eligible Employees may choose. This selection may include different coverage levels, such as employee only, employee + spouse, employee + child(ren), and family. Certain component benefit programs may be separately elected, while others may only be elected in conjunction with other component benefit programs, as more fully described in the applicable Attachments. This is true for all actively employed eligible Employees and their Dependents, as well as COBRA beneficiaries. The benefits may be provided through contracts of insurance with insurance companies (the "***Insurers***") in return for premium payments paid to the Insurers, or the benefits may be self-funded by the College.

The cost of coverage may vary depending on which coverage option the Participant selects. The cost of the benefits provided through the component benefit programs may be funded entirely by employee contributions, entirely by contributions from the College, or in part by contributions from the College and in part by employee contributions. Employee contributions may be pre-tax or after-tax, subject to the terms of the applicable component benefit program. The College will communicate the Participant's share of the cost for benefits provided through each component benefit program during the annual enrollment period each year, or more often as the College determines is necessary.

Eligible Employees will have the opportunity to enroll in the component benefit programs when they first become eligible and at least once per year thereafter, as described in the "*Eligibility and Enrollment*" section above. Generally, Participants may only change their benefit elections during annual enrollment. However, Participants may be permitted to change their benefit elections, including the amount of their pre-tax contributions, only if they experience certain qualifying changes. See the "*Eligibility and Enrollment*" section of this document for more information.

Plan operating expenses are paid from Plan assets or the general assets of the Employer.

Any surplus, reserves, return of premiums or assets from which time to time may be held under the Plan shall be considered to consist solely of employer contributions to the extent such surplus, reserves, return of premiums or assets do not exceed the aggregate employer contributions during the period in which the surplus, reserves, return of premiums or assets accumulated.

ARTICLE V

ADMINISTRATION

Plan Administrator

The College is the Plan Administrator. The College may delegate to one or more persons or committees the authority to perform all or some of the fiduciary functions. Such delegations will be hereby incorporated by reference. If a component benefit program names an administrator other than the College for some or all administrative functions, such administrator shall assume the delegated duties of the Plan Administrator for that component benefit program.

The Plan Administrator (and its designee) shall administer the Plan in accordance with its terms and shall establish its policies, interpretations, practices, and procedures. The Plan Administrator (and its designee) shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues that relate to eligibility to participate in the Plan and that relate to eligibility for benefits, to decide disputes that may arise relative to a Participant's rights, to decide questions of Plan interpretation and those of fact relating to the Plan, and to decide all questions regarding any claim for benefits under the Plan. The decisions of the Plan Administrator (and its designee) will be final and binding upon all interested parties.

Duties of the Plan Administrator

The Plan Administrator (and its designee) shall have the following duties and responsibilities:

1. To administer the Plan in accordance with its terms;
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies, mistakes, or omissions;
3. To decide disputes that may arise relative to an employee's eligibility for any component benefit program and a Participant's rights under the Plan;
4. To prescribe procedures for filing a claim for benefits and for the review of claim denials;
5. To keep and maintain the Plan documents and all other records pertaining to the Plan;
6. To appoint a claims administrator to pay claims;
7. To perform all necessary reporting as required by ERISA;
8. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA;
9. To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate; and
10. To require any person to furnish such reasonable information as the Plan Administrator may request for the administration of the Plan as a condition to receiving any benefits under the Plan.

Plan Administrator Compensation

The Plan Administrator serves without compensation. However, all expenses for Plan administration, including compensation for hired services, will be paid by the Plan.

ARTICLE VI

AMENDMENT AND TERMINATION

Amendment and Termination

The Plan Sponsor intends to maintain this Plan, as amended from time to time, indefinitely. However, it reserves the right, at any time, to amend, suspend, or terminate the Plan in whole or in part. The right to change the Plan includes, but is not limited to, amending the eligibility provisions of the Plan and amending the component benefit programs available under the Plan. Pursuant to the terms in the group insurance contract(s), the College can amend or replace the group insurance contract(s) through which any component benefit programs are provided under the Plan. If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination. Any amendment that is necessary to bring this Plan into conformity with the law may be made retroactively. Any such amendment, suspension, or termination shall be communicated to Participants in the Plan (to the extent required by applicable law).

The Attachments may be updated and amended from time-to-time without the need for a formal amendment of the Plan document.

ARTICLE VII

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

This Article has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("***COBRA***"). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

Benefits Not Eligible for COBRA Continuation Coverage

Life insurance and disability benefits are not eligible for continuing coverage under COBRA.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "***Qualifying Event***." Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "***Qualified Beneficiary***." You, your Spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;

- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your Dependents will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. The Employer must notify the Plan Administrator of the following Qualifying Events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

You Must Give Notice of Some Qualifying Events

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a dependent child's losing eligibility for coverage as a Dependent), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to the College by completing and submitting the forms and documents required by the Plan Administrator.

A dependent Qualified Beneficiary may submit valid legal document(s) to the College's Group Insurance Department in place of the form. The documents must enable the Plan Administrator to determine that a Qualifying Event has occurred and identify the Qualified Beneficiaries. Additional legal documentation may be requested by the Plan Administrator.

How Is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA

continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the Qualifying Event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months). Otherwise, when the Qualifying Event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

A copy of the Social Security Administration ("***SSA***") disability determination letter must be provided to the College within 60 days of receiving the disability determination or upon COBRA enrollment, whichever is later. Notification must be given prior to the end of the initial 18-month period. Failure to provide this notice in a timely manner may result in denial of the disability extension. If the SSA changes the determination and finds that the Qualified Beneficiary is no longer disabled, a copy of the revised determination must be provided to the College within 30 days.

Second Qualifying Event extension of 18-month period of continuation coverage

If your family experiences another Qualifying Event during the 18 months of COBRA continuation coverage, the Spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Payment Requirements

You must submit any payment required for COBRA continuation coverage to the Plan Administrator at the address indicated on your payment notice. If you do not enroll when first becoming eligible, the payment

due for the period between the date you first become eligible and the date you enroll for COBRA continuation coverage must be paid to the Employer within 45 days after the date you enroll for COBRA continuation coverage. After enrolling for COBRA continuation coverage, all payments are due and payable on a monthly basis, on the first of each month, with a 30-day grace period. Failure to make payment within the 30-day grace period will result in termination of COBRA continuation coverage without reinstatement.

How Long Is COBRA Coverage Provided?

COBRA continuation coverage is available for a maximum of:

- 18 months if the loss of coverage is caused by termination of employment or reduction in hours of employments; or
- 29 months of coverage if the criteria for a disability extension is met; or
- 36 months for other Qualifying Events. If a Spouse or covered Dependent is eligible for 18 months of COBRA continuation coverage as described above, and there is a second Qualifying Event (e.g. divorce), the Spouse and Dependent may be eligible for 36 months of COBRA continuation coverage from the date of the first Qualifying Event.

When Will COBRA Continuation Coverage End?

After you have elected COBRA continuation coverage, that coverage will terminate either at the end of the applicable 18, 29 or 36 month eligibility period, or before the end of that period, upon the date that:

- The Employer ceases to provide a group health plan to any Employee; or
- Payment for such coverage is not submitted when due; or
- The date that you, otherwise eligible for 29 months of COBRA continuation coverage, are determined to no longer be disabled for purposes of the COBRA law; or
- You become covered as either a subscriber of dependent by another group health care plan, and that coverage does not contain any exclusion or limitation with respect to any preexisting condition of the Qualified Beneficiary (other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary by reason of the provisions in Code Section 9801 (relating to limitations on preexisting condition exclusion periods in group health plans).

However, a Qualified Beneficiary who becomes covered under a group health plan which has a preexisting condition limit with respect to a preexisting condition of the Qualified Beneficiary must be allowed to continue COBRA continuation coverage for the length of a preexisting condition limit or to the COBRA maximum time period, whichever is less. COBRA coverage may be terminated if the Qualified Beneficiary becomes covered under a group health plan with a preexisting condition limit (as defined in COBRA) if the preexisting condition limit does not apply (or is satisfied by) the Qualified Beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996 ("***HIPAA***").

Are There Other Coverage Options Besides Cobra Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as your Spouse's plan) through what is called a "***special enrollment period***." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What Is the Health Insurance Marketplace?

The Marketplace offers one-stop shopping to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program ("***CHIP***"). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When Can I Enroll in Marketplace Coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a special enrollment event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an open enrollment period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about Qualifying Events and special enrollment periods, visit www.HealthCare.gov.

If I Sign Up for COBRA Continuation Coverage, Can I Switch to Coverage in the Marketplace? What About If I Choose Marketplace Coverage and Want to Switch Back to COBRA Continuation Coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child

through something called a special enrollment period. But be careful though - if you terminate your COBRA continuation coverage early without another Qualifying Event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I Enroll in Another Group Health Plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What Factors Should I Consider When Choosing Coverage Options?

When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.

- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.

- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.

- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.

- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.

- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For

example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("***EBSA"***) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep the Plan Administrator Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Administrator Contact Information:

Birmingham Southern College
900 Arkadelphia Road
Box 549090
Birmingham, AL 35254
(205) 226-4646

ARTICLE VIII

HIPAA

Notwithstanding anything in this Plan to the contrary, any component benefit program that is a Covered Entity shall be operated in accordance with the Privacy and Security Standards of HIPAA and their related regulations (the "***HIPAA regulations***"), including but not limited to, the Health Information Technology for Economic and Clinical Health Act (the "***HITECH Act***").

Employees of the Employer may have access to individually identifiable health information of Participants. This information is protected health information ("***PHI***").

Disclosures of PHI

Employees may disclose to the Employer information on whether an individual is participating in the Plan and, subject to the conditions described below and as otherwise permitted by law, may disclose PHI to the Employer, provided the Employer uses or discloses the PHI only for Plan administration purposes. Employees may disclose summary health information to the College if the College requests it in order to modify, amend, or terminate the Plan or any component benefit program.

The College, as Plan Administrator, agrees that, other than enrollment and disenrollment information and summary health information, the Employer will:

1. Not use or further disclose PHI other than as permitted or required by the Plan or any component benefit program, or as required by law;

2. Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan or any component benefit program agrees in writing to the same restrictions and conditions that apply to the Employer with respect to the PHI and to implement reasonable and appropriate safeguards to protect electronic PHI;

3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

4. Report to the Plan any use or disclosure of PHI that is inconsistent with the permitted uses or disclosures of which it becomes aware;

5. Make PHI available to comply with HIPAA's right of access in accordance with the HIPAA regulations;

6. Make PHI available for amendment, and incorporate any amendments of PHI, in accordance with the HIPAA regulations;

7. Make available the information required to provide an accounting of disclosures in accordance with the HIPAA regulations;

8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan or a component benefit program available to the Secretary of Health and Human Services in order to determine compliance by the Plan or any component benefit program with HIPAA's privacy requirements;

9. If feasible, return or destroy all PHI received from the Plan or a component benefit program that the Employer still maintains in any form and retain no copies of the information when no longer needed for the purpose for which disclosure was made, except that, if the return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

10. Ensure that adequate separation between the Plan and component benefit programs and the Employer as required by the HIPAA regulations is satisfied;

11. If it creates, receives, maintains, or transmits any electronic PHI on behalf of the Plan or a component benefit program, implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and ensure that any agents to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information;

12. Report to the Plan and, if applicable, component benefit program any security incident of which it becomes aware; and

13. To the extent that the Employer uses or maintains electronic health records with respect to PHI, ensure that an individual has the ability to exercise his right to receive an accounting from the Employer of disclosures of the individual's electronic health records that have been made by the Employer in the three years prior to the individual's request for an accounting, including: (a) disclosures made to carry out health care treatment, payment, and operations; (b) disclosures not permitted by the privacy rule; (c) disclosures the Employer makes pursuant to a "public policy" purpose; (d) disclosures required by law; and (e) disclosures made pursuant to an administrative or judicial order, subpoena, discovery request, qualified medical child support order, or workers' compensation program.

Minimum Necessary

When using or disclosing PHI or when requesting PHI from another party, the Plan will make reasonable efforts to limit PHI to: (1) the minimum necessary to accomplish the intended purpose of the use or disclosure, or to satisfy the purpose of a request; or (2) a limited data set for purposes of health care operations.

Non-Compliance

In the event of non-compliance with any of the provisions set forth in this section, the HIPAA Privacy Officer will address any compliance issues promptly and confidentially by investigating the complaint and documenting their investigation efforts and findings. If PHI has been used or disclosed in violation of the Privacy Policy or inconsistent with this section, the HIPAA Privacy Officer shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur. If an authorized employee or other employee is found to have violated the Privacy Policy, the employee will be subject to disciplinary action up to and including termination of employment.

Discovery of Breach

Following the discovery of a breach of unsecured PHI, the Plan Administrator will notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of the breach, in accordance with 45 C.F.R. Section 164.404, as amended, and will notify the Secretary of Health and Human Services in accordance with 45 C.F.R. Section 164.408, as amended. For

a breach of unsecured PHI involving more than 500 residents of a state or jurisdiction, the Plan Administrator will notify the media in accordance with 45 C.F.R. Section 164.406, as amended. "Unsecured PHI" means PHI that is not secured through the use of technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

ARTICLE IX

CLAIMS PROCEDURES

If a component benefit program has its own procedures governing how claims and appeals are processed under that program, then those procedures will apply. To the extent that a component benefit program does not have procedures governing how claims and appeals are processed under that program, then the following procedures will apply.

Submitting a Claim

A "**Claim**" is a request that benefits under the Plan be paid. A Claim is incurred on the date the services or supplies are provided.

The provider of services should submit Claims to the claims administrator for the applicable component benefit program. The claims administrator for each component benefit program is described in the Attachments.

All Claims must be submitted by the earlier of the time period set forth in the Attachment or three hundred sixty five (365) days after the Claim is incurred.

Group Health Plan Claims

"**Group Health Plan Claims**" are Claims under a component benefit program that is a Group Health Plan. There are four types of Group Health Plan Claims: Urgent Care Claims, Concurrent Care Claims, Pre-Service Claims, and Post-Service Claims.

Urgent Care Claims

An Urgent Care Claim is a request for the preauthorization of medical care or treatment where using the standard time frames for the preauthorization process could seriously jeopardize the claimant's life or health or ability to regain maximum function, or would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

Urgent Care Claims are always Pre-Service Claims or Concurrent Care Claims to extend a previously-approved course of treatment that must be preauthorized by the Plan. Post-Service Claims are never Urgent Care Claims because the service has already been provided. Whether a Claim is an Urgent Care Claim is decided at the time the preauthorization request is being processed. If requested services are provided before the Claim for Preauthorization is processed, or while it is being processed, the Claim is no longer considered an Urgent Care Claim.

If the claimant submits an Urgent Care Claim that identifies the claimant, the medical condition, and the service involved to someone who is customarily responsible for handling benefit matters, but who is the wrong person to receive an Urgent Care Claim request, the Plan will advise the claimant of the proper procedures as soon as possible, but no later than 2 hours after receiving the Claim.

The Plan Administrator (or its designee) will notify the claimant of its decision on an Urgent Care Claim as soon as possible (whether adverse or not), taking into account the medical exigencies, but no later than 72 hours after the Plan's receipt of the Claim, unless the Claim is incomplete.

If a request for preauthorization is made to extend the course of treatment for Urgent Care beyond the time period or number of treatments originally approved, then the Plan Administrator (or its designee) will respond to the Claim as soon as possible, but no later than 24 hours after the Claim for preauthorization is received, if the Claim is filed at least 24 hours before expiration of the originally approved course of treatment.

If an Urgent Care Claim is incomplete, the Plan Administrator (or its designee) will notify the claimant of the information necessary to complete the Claim as soon as possible, but no later than 24 hours after the Plan receives the Claim. The claimant has a reasonable period of time (but not less than 48 hours) to provide the additional information. As soon as possible, but no more than 48 hours after the Plan receives the additional information, or after the claimant's deadline for providing the additional information, if earlier, the Plan Administrator (or its designee) will notify the claimant of its decision on the Claim. The Plan's decision may be provided orally, with a written or electronic notification furnished within 3 days.

If the Plan Administrator (or its designee) partially or completely denies the Claim for Urgent Care, the claimant may orally or in writing request an expedited appeal of the decision, and the Plan Administrator (or its designee) will notify the claimant of its decision on the appeal by telephone, facsimile or electronically as soon as possible, but not later than 72 hours after the appeal is filed.

Concurrent Care Claims

If the Plan has approved an ongoing course of treatment that will be provided over a period of time or will include a certain number of treatments, and the Plan Administrator (or its designee) decides to reduce or terminate the period of time or number of treatments, it will give notice to the claimant sufficiently in advance to allow the claimant to appeal the decision before the benefits are reduced or terminated.

Pre-Service Claims

A Pre-Service Claim is a request for a determination whether medical services are medically necessary in advance of the services where the Claim or benefit level will be denied if preauthorization is not obtained.

For a Pre-Service Claim, the Plan Administrator (or its designee) will notify the claimant of its decision (whether adverse or not) within a reasonable time period, but no later than fifteen (15) days after the Plan receives the Claim.

This 15-day period may be extended for another fifteen (15) days if the Plan Administrator (or its designee) determines that the extension is necessary due to matters beyond its control and it notifies the claimant during the initial 15-day period of the extension of the reason for the extension and the date by which the Plan expects to make a decision. If the extension is necessary because the claimant failed to submit necessary information, the Plan Administrator (or its designee) will also describe the additional information needed. The claimant will have at least forty-five (45) days from receipt of this notice to provide the requested information.

If the claimant submits a Pre-Service Claim that identifies the claimant, the medical condition and the service involved to someone who is customarily responsible for handling benefit matters, but is the wrong person to receive a Pre-Service Claim, the Plan Administrator (or its designee) will advise the claimant of the proper procedures as soon as possible, but no later than five (5) days after receiving the claim.

If the Plan Administrator (or its designee) partially or completely denies a Pre-Service Claim, the claimant may appeal the decision within one-hundred and eighty (180) days of receiving the adverse decision, and the Plan Administrator (or its designee) will notify the claimant of its decision on the appeal within a

reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after the appeal is filed.

Post-Service Claims

A Post-Service Claim is any Claim that is not an Urgent Care Claim, Concurrent Care Claim or Pre-Service Claim. The claimant is requesting reimbursement for or payment of care that has already been received.

The Plan Administrator (or its designee) will notify a claimant of its decision on a Post-Service Claim within a reasonable time period, but no later than thirty (30) days after the Claim is received.

This 30-day period may be extended for another fifteen (15) days if the Plan Administrator (or its designee) determines that the extension is necessary due to matters beyond its control, and the Plan Administrator (or its designee) notifies the claimant during the initial 30-day period of the extension, the reason for the extension, and the date by which the Plan expects to make a decision. If the extension is necessary because the Claim is incomplete, the Plan Administrator (or its designee) will also describe the additional information necessary to complete the Claim. The claimant will have at least forty-five (45) days from receipt of this notice to provide the requested information.

If the Plan Administrator (or its designee) partially or completely denies a Post-Service Claim, the claimant may appeal the decision within one hundred eighty (180) days of receiving the adverse decision, and the Plan Administrator (or its designee) will notify the claimant of its decision on the appeal within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after the appeal is filed.

Disability Claims

A Disability Claim is a Claim under a component benefit program that provides disability benefits or makes a determination of disability. Notwithstanding any other language in the Plan to the contrary, the following procedures apply with respect to claims for disability benefits or determinations of disability on or after April 1, 2018. These procedures are limited to claims where benefits are based on disability and the Plan Administrator is determining whether a claimant satisfies the definition of disability under the Plan or a component benefit program. These procedures do not apply if the Plan relies on an independent disability determination, such as whether a claimant qualifies for Social Security Disability benefits, or where eligibility for benefits under a component benefit program other than the long-term disability component benefit are determined based on the determination made under the long-term disability component benefit.

These procedures are intended to comply with the ERISA requirements set forth in DOL Regulation §2560.503-1, and the Plan Administrator will interpret these procedures in accordance with such regulations.

The component benefit program may offer additional voluntary appeal and/or mandatory arbitration procedures other than those described here. If applicable, the component benefit program will not assert that a claimant has failed to exhaust administrative remedies due to the claimant's failure to utilize any voluntary procedures. Further any statute of limitations is tolled during the period that a claimant's voluntary appeal is pending.

For purposes of these disability claims procedures, a document, record, or other information shall be considered relevant to a claim if it:

- was relied upon in making the benefit determination;

- was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

Submitting a Claim for Disability Benefits

You may file a claim for benefits by submitting a written request for benefits to the Plan Administrator. You should contact the Plan Administrator to see if there is an applicable form that must be used. If no specific form is required, then your written assertion that your benefits under the Plan have been determined incorrectly will be considered a claim for benefits under these procedures.

The claim for benefits must include sufficient evidence to enable the Plan Administrator to determine whether you have met the Plan's definition of disability.

Decisions on the claim will be made within a reasonable period of time appropriate to the circumstances.

"Days" means calendar days. If the Plan Administrator determines the claim is valid, then you will receive a statement describing the amount of benefit, the method or methods of payment, the timing of distributions and other information relevant to the payment of the benefit.

Initial Disability Claims

The Plan shall notify the claimant of the approval or the denial of the claim for benefits on account of Disability within 45 days after receipt unless, due to circumstances beyond the control of the Plan, an extension of time for processing the claim is required.

If the Plan needs such an extension, the Plan shall furnish a written notice to the claimant before the end of the initial 45-day period that the review period will be extended by 30 days. If, before the end of the first extension period, the Plan determines that circumstances beyond their control prevent a decision from being rendered within that period, it may be extended for an additional 30 days, provided that the Plan notifies the claimant before the end of the first extension period.

In the case of either extension as described above, the written notice shall specify the circumstances requiring an extension and the date by which the Plan expects to reach a final decision. That date shall not be later than 75 days after the date on which the claim was filed, in the case of a first extension, or 105 days after the date on which the claim was filed, in the case of a second extension.

The notice of extension shall specifically explain: (i) the standards on which entitlement to a benefit is based, (ii) the unresolved issues that prevent a final decision from being rendered, (iii) the additional information needed to resolve those issues, and (iv) that the claimant has 45 days in which to provide the information. If the claimant must provide additional information, the review period shall be tolled until the information is provided.

Denial of a Disability Benefit Claim

If the Plan Administrator determines that all or part of the claim should be denied (an "adverse benefit determination"), it will provide a notice of its decision in written or electronic form explaining the

claimant's appeal rights. An "adverse benefit determination" also includes a rescission, which is a retroactive cancellation or termination of entitlement to disability benefits. The notice will be provided in a culturally and linguistically appropriate manner and will state:

- The specific reason or reasons for the adverse determination.
- Reference to the specific Plan provisions on which the determination was based.
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
    - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or
    - a disability determination made by the Social Security Administration regarding the claimant and presented by the claimant to the Plan.
- If the adverse benefit determination is based on medical necessity or experimental and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge upon request.
- Either the specific internal rules, guidelines, protocols, or other similar criteria relied upon to make a determination, or a statement that such rules, guidelines, protocols, or criteria do not exist.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Review of Adverse Disability Benefit Determinations

When a claim for benefits on account of disability is denied, in whole or in part, the claimant shall have the right to request that the Plan reviews the denial, provided that the request is made in writing within 180 days of receiving written notification of the denial. The request must be in writing and must be filed within 180 days following receipt of the notice. In the case of an adverse benefit determination regarding a rescission of coverage, the claimant must request a review within 90 days of the notice. The claimant or his authorized representative may submit written comments, documents, records, and other information relating to the claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review shall not give deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor a subordinate of such individual.

In reviewing an adverse benefit determination of a claim for benefits on account of disability that is based in whole or in part on a medical judgment, the Plan shall consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment. That health care

professional shall be neither an individual who was consulted in connection with the initial adverse benefit determination, nor a subordinate of any such individual. In addition, the Plan shall identify medical or vocational experts whose advice was obtained in connection with the claimant's adverse benefit determination, without regard to whether their advice was relied upon.

The Plan will provide the claimant, free of charge, with the following items before issuing an adverse benefit determination on appeal: any new or additional evidence considered, relied upon, or created during the review of the adverse benefit determination; any new or additional rationale for an adverse benefit determination, provided that such rationale is the basis for the adverse benefit determination on appeal. Such new additional evidence or rationale will be provided as soon as possible and sufficiently in advance of the deadline for issuing an adverse benefit determination on appeal so that the claimant will have an opportunity to respond.

Before the Plan issues an adverse benefit determination on review that is based on a new or additional rationale, the claimant must be provided a copy of the rationale at no cost to the claimant. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on appeal is required to allow the claimant time to respond.

The claimant will be notified of the determination on review of the claim no later than 45 days after the Plan's receipt of the request for review, unless special circumstances require an extension of time for processing. In such a case, the claimant will be notified, before the end of the initial review period, of the special circumstances requiring the extension and the date a decision is expected. Including any extension, the Plan Administrator must notify the claimant of the determination on review no later than 90 days after receipt of the request for review.

Notice of Adverse Disability Benefit Determination on Review

The Plan Administrator shall provide written or electronic notification to the claimant or his authorized representative in a culturally and linguistically appropriate manner. If the initial adverse benefit determination is upheld on review, the notice will include:

- The specific reason or reasons for the adverse determination.
- Reference to the specific provisions of the Plan on which the determination was based.
- A statement of claimant's entitlement to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
- A statement of claimant's right to bring a civil action under section 502(a) of ERISA and, if the Plan imposes a contractual limitations period that applies to claimant's right to bring such an action, a statement to that effect which includes the calendar date on which such limitation for bringing such an action expires on the claim.

  If the Plan offers voluntary appeal procedures, a description of those procedures and the claimant's right to obtain sufficient information about those procedures upon request to enable the claimant to make an informed decision about whether to submit to such voluntary appeal. These procedures will include a description of the claimant's right to representation, as well as the process for selecting the decision maker and the circumstances, if any, that may affect the impartiality of the decision maker. No fees or costs will be imposed on the claimant as part of the voluntary appeal. A claimant's decision whether to use the voluntary appeal process will have no effect on the claimant's rights to any other Plan benefits.
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

    - the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
    - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or
    - a disability determination made by the Social Security Administration regarding the claimant and presented by the claimant to the Plan.
- If the adverse benefit determination is based on medical necessity or experimental and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.
- Either the specific internal rules, guidelines, protocols, or other similar criteria relied upon to make the determination, or a statement that such rules, guidelines, protocols, or criteria do not exist.

Other Non-Health Claims

The Plan Administrator (or its designee) will notify a claimant of its decision on a Claim that is not a Group Health Plan Claim or a Disability Claim within a reasonable time period, but no later than ninety (90) days after the Claim is received.

This 90-day period may be extended for an additional ninety (90) days if the Plan Administrator (or its designee) determines that special circumstances require an extension of time for processing the Claim, and the Plan Administrator (or its designee) notifies the claimant during the initial 90-day period of the extension and provides a reason for the extension and the date by which the Plan expects to make a decision.

If the Plan Administrator (or its designee) partially or completely denies a Claim that is not a Group Health Plan Claim or a Disability Claim, the claimant may appeal the decision within sixty (60) days of receiving the adverse decision, and the Plan Administrator (or its designee) will notify the claimant of its decision on the appeal within a reasonable period of time, but not later than sixty (60) days after the appeal is filed.

Internal Appeals Procedures

Full and Fair Review On Internal Appeal

During a Claim Appeal, the Plan Administrator (or its designee):

1. Will provide claimants with the opportunity to submit written comments, documents, records, and other information relating to the Claim;

2. Will provide that the claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information "relevant" to the claimant's Claim; and

3. Will provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination.

During a Claim Appeal for a Group Health Plan Claim, in addition to the items listed above, the Plan Administrator (or its designee):

1. Will provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

2. Will provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

3. Will provide that the health care professional engaged for purposes of a consultation under the above provision shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

4. Will, upon request, provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

During a Claim Appeal for a Group Health Plan Claim, in addition to the items listed above, the Plan Administrator (or its designee):

1. Will allow the claimant to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process;

2. Will provide the claimant, free of charge and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided in order to give the claimant a reasonable opportunity to respond, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the Claim;

3. Will provide the claimant, free of charge and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided in order to give the claimant a reasonable opportunity to respond, with any new or additional rationale; and

4. Will, for an Urgent Care Claim, provide an expedited review process pursuant to which: (a) a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and (b) all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

Definition of "Relevant"

Information is "relevant" to a claim for purposes of this section if:

1. it was relied on to decide the Claim;

2. it was submitted, considered or generated while deciding the Claim, whether or not it was relied upon;

3. it demonstrates compliance with the administrative processes used to verify that Claim decisions are made in accordance with the Plan documents and that Plan provisions have been applied consistently to similarly situated individuals; or

4. it is a statement of policy or guidance regarding the treatment denied for the claimant's diagnosis, whether or not it was relied on.

Rescission of Coverage

If the Plan Administrator (or its designee) rescinds a claimant's health plan coverage retroactively in a Rescission, the claimant may appeal that decision under these Appeal procedures and the external review procedures below, even if the Rescission does not have a negative adverse effect on any particular benefit at the time of the Rescission.

General Rules Applicable to Internal Claims and Internal Appeals

If the provisions of this "*Claims Procedures*" section apply, the Plan Administrator (or its designee) will have the sole discretion to make the determination of all internal Claims and Appeals. Benefits will be paid only if the Plan Administrator (or its designee) decides in its full and absolute discretion that the claimant is entitled to benefits.

The time period for making an initial or Appeal Claim decision shall begin on the date a Claim or Appeal is filed in accord with the Plan's claims procedures, whether or not all the information necessary to make a decision has been filed. If a decision time period is extended because the claimant must submit more information, the decision time period is tolled from the date the claimant is notified that more information is needed until the claimant provides the additional information; provided, however, that if the claimant does not provide any additional information within forty-five (45) days from receipt of the notice that additional information is necessary, the Plan Administrator may make an initial or Appeal Claim decision.

Decisions regarding the hiring, compensation, termination, promotion, or other similar matters regarding persons who are involved in making Claims and Appeals decisions (e.g., claims adjudicators and medical experts) will not be based upon the likelihood that the individual will support the denial of benefits.

If the Plan Administrator (or its designee) denies a claimant's initial Claim for benefits or Appeal, the written or electronic denial will include in a culturally and linguistically appropriate manner:

1. The specific reasons for the adverse decision or denial;

2. Reference to the specific Plan provision on which the decision is based;

3. A description of any information necessary to complete the Claim, and an explanation of why the information is needed;

4. For an initial denial of a Claim, a description of the Plan's internal review procedures and external review processes, including information regarding how to initiate an Appeal, the time limits for an Appeal, and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA only following exhaustion or deemed exhaustion of the internal Claim and Appeal procedures; and

5. For a denial on Appeal, a discussion of the decision, a statement of the claimant's right to external review and to bring an action under Section 502(a) of ERISA only following exhaustion or deemed exhaustion of the internal Claim and Appeal procedures.

If the Plan Administrator (or its designee) denies a claimant's initial Claim for benefits or Appeal for a Claim that was a Group Health Plan Claim, in addition to the above items, the denial will include:

1. Any specific internal rule, guideline, protocol, standard or criterion relied on in making the decision, or a statement that a criterion was relied on and will be provided free of charge upon request; and

2. For any decision based on the requirement that services be medically necessary or the exclusion of experimental or investigative services, an explanation of the scientific or clinical judgment for the decision, applying the Plan terms to the claimant's medical circumstances, or a statement that the explanation will be provided free of charge upon request.

If the Plan Administrator (or its designee) denies a claimant's initial Claim for benefits or Appeal for a Claim that was a Group Health Plan Claim, in addition to the above items, the denial will include:

1. Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

2. The denial code and its corresponding meaning, as well as a description of the of the Plan's standard, if any, that was used in denying the Claim;

3. A description of available internal appeals (for initial Claim denials) and external review processes, including information regarding how to initiate an appeal; and

4. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

If the Plan Administrator (or its designee) fails to adhere to the regulatory requirements for claims processing:

1. The claimant is deemed to have exhausted the internal Claims and Appeals processes of the Plan, unless the failure is de minimis and it does not cause and is not likely to cause prejudice or harm to the claimant, so long as the Plan Administrator (or its designee) demonstrates that the failure was for good cause or due to matters beyond the control of the Plan and the failure occurred in the context of an ongoing, good faith exchange of information between the Plan Administrator (or its designee) and the claimant, and the failure was not part of a pattern or practice of violations by the Plan Administrator (or its designee);

2. The claimant is entitled to pursue any available remedies under ERISA, including, where applicable an external review; and

3. The Claim or Appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

The claimant may request from the Plan Administrator (or its designee) a written explanation of the violation of the regulatory requirements for claims processing, and the Plan Administrator (or its designee) will provide it within ten (10) days, including the Plan Administrator's (or its designee's) basis for asserting that the violation should not cause the internal Claims and Appeals process to be deemed exhausted.

If an external reviewer or court rejects the claimant's request for immediate review because the Plan Administrator's (or its designee's) failure was de minimis, the claimant may resubmit the Claim and pursue the internal Appeal of the Claim. Within ten days of the decision of the external reviewer or court to reject the Claim for immediate review, the Plan will notify the claimant of the claimant's right to resubmit the Claim for internal Appeal. The time period for re-filing the Claim begins to run upon claimant's receipt of the notice.

External Review Procedures for Group Health Plan Claims

A claimant may file a request for External Review of a Group Health Plan Claim with the Plan if the request is filed within four (4) months after receipt of a notice of an adverse benefit determination on the claimant's internal Appeal if the adverse benefit determination involves a Rescission of coverage or a medical judgment, including, but not limited to, medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigative.

If there is no corresponding date four (4) months after the date the denial is received, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

A denial, reduction, termination or failure to pay a benefit based on a determination that a participant does not meet the eligibility requirements of the Plan is not eligible for External Review.

Preliminary Review of Request for External Review

Within five (5) business days following receipt of the External Review request, the Plan Administrator (or its designee) must complete a preliminary review of the request to determine whether:

1. The claimant is or was covered under the Plan at the time the health care item or service was requested or provided;

2. The Claim denial is eligible for External Review;

3. The claimant has exhausted the Plan's internal Claims and Appeal process (or, the claimant is deemed to have exhausted the internal Claims and Appeal process); and

4. The claimant has provided all the information and forms required to process an External Review.

Within one (1) business day after completing the preliminary review, the Plan Administrator (or its designee) must notify the claimant of its findings in writing. If the request is complete but not eligible for External Review, the notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notification must describe the information or materials needed to make the request complete, and the Plan must allow the claimant to perfect the request for External Review within the four-

month filing period or within the 48-hour period following the claimant's receipt of the notification, whichever is later.

Referral to Independent Review Organization

The Plan Administrator (or its designee) will assign an independent review organization ("IRO") that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. The Plan Administrator, or its designee, will rotate claims assignments among its IRO's (or incorporate other independent, unbiased methods for selection of IRO's, such as random selection). The IRO will not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

The assigned IRO will timely notify the claimant in writing that the claimant's request is eligible for External Review and that it has been accepted for External Review. This notice will include a statement that the claimant may submit additional information in writing to the assigned IRO within ten business days following receipt of the notice, and that the IRO will consider the information when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days.

Within five (5) business days after the IRO is assigned to the claim, the Plan Administrator (or its designee) will provide to the assigned IRO the documents and information considered in making the benefit determination. If the Plan Administrator (or its designee) fails to timely provide the documents and information, the assigned IRO may terminate the External Review and reverse the adverse benefit determination. Within one (1) business day after making this decision, the IRO will notify the claimant and the Plan Administrator (or its designee).

If the IRO receives any information from the claimant, the IRO must within one business day forward the information to the Plan Administrator (or its designee). Upon receipt of the information, the Plan Administrator (or its designee) may reconsider its adverse benefit determination that is the subject of the External Review. The External Review will be terminated as a result of the Plan's reconsideration only if the Plan decides to reverse its adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan Administrator (or its designee) must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO will terminate the External Review upon receipt of the notice from the Plan Administrator (or its designee).

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the Claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal Claim or Appeal process.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

1. The claimant's medical records;

2. The attending health care professional's recommendation;

3. Reports from appropriate health care professionals and other documents submitted by the Plan, claimant, or the claimant's treating provider;

4. The terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

5. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, or national or professional medical societies, boards, and associations;

6. Any applicable clinical review criteria developed and used by the Plan Administrator (or its designee), unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

7. The opinion of the IRO's clinical reviewer or reviewers after considering the information and documents available, to the extent the clinical reviewer or reviewers consider appropriate.

The assigned IRO will provide written notice of the final External Review decision within 45 days after the IRO receives the request for the External Review. The IRO will deliver the notice of final External Review decision to the claimant and the Plan.

The assigned IRO's decision will contain:

1. A general description of the reason for the request for External Review, including information sufficient to identify the Claim, including the date or dates of service, the health care provider, the Claim amount (if applicable), and the reason for the previous denial;

2. The date the IRO received the assignment to conduct the External Review and the date of the IRO decision;

3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

5. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to the claimant;

6. A statement that judicial review may be available to the claimant; and

7. Current contact information, including the phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act Section 2793.

Record Retention

After a final External Review decision, the IRO will maintain records of all Claims and notices associated with the External Review process for six years. The IRO will make these records available for examination by the claimant, the Plan, or a State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Reversal of Plan's Decision

Upon receiving a final External Review decision reversing an adverse benefit determination, the Plan will immediately provide coverage or immediately pay the Claim.

Expedited External Review of an Urgent Care Claim

A claimant may request an expedited External Review of an Urgent Care Claim if the claimant receives:

1. An initial Claim denial for a medical condition of the claimant for which the timeframe for completion of an expedited internal Appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, and the claimant has filed a request for an expedited internal appeal; or

2. A denial on Appeal if the claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final Appeal denial concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited External Review, the Plan Administrator (or its designee) will determine whether the request meets the reviewability requirements for External Review. The Plan will immediately send to the claimant a notice of its decision that meets the requirements set forth in the "*Preliminary Review of Request for External Review*" section above for standard External Review.

Upon a determination that a request is eligible for External Review, the Plan will assign an IRO pursuant to the requirements set forth in the "*Referral to Independent Review Organization*" section above for standard review. The Plan Administrator (or its designee) will provide to the assigned IRO all necessary documents and information considered in making the adverse benefit determination, by telephone or facsimile or electronically or by any other available expeditious method. The assigned IRO will consider the information or documents described above under the procedures for standard review.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth in the "*Referral to Independent Review Organization*" section above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the notice is not provided in writing, then within 48 hours after the date of providing the notice, the IRO will provide written confirmation of the decision to the claimant and the Plan Administrator (or its designee).

Claims Litigation

If an individual's claim has been partially or completely denied, and the individual has exhausted all applicable internal and external claims and appeals procedures under this "*Claims Procedures*" section of the Plan or a component benefit program's relevant claims and appeals procedures, as applicable, the individual may bring an action under Section 502(a) of ERISA. However, no such legal action may be brought more than three (3) years following the date of the first decision on the claim.

ARTICLE X

PARTICIPANT RIGHTS

Rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at EBSA's Public Disclosure Room.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated SPD. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this document for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support

order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of EBSA, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA's publications hotline.

Rights under the Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

Rights under the Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (***WHCRA***). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

Rights under USERRA

If you are returning from uniformed service, you have certain rights with respect to the Plan pursuant to USERRA. In addition, special health care continuation coverage rules may apply while you are performing military service. Contact the Plan Administrator for more information.

Rights under FMLA

If you take a leave of absence that is covered by the FMLA, you may be able to continue your health coverage during your leave. Coverage will only be continued if you continue to pay premiums for coverage. If you drop your health coverage during the leave, you can have your health coverage reinstated on the date you return to work, if you apply for coverage within thirty (30) days of your return to work and pay any contributions required for the coverage. Contact the Plan Administrator for more information.

Children's Health Insurance Program Reauthorization Act of 2009

Notwithstanding any provision of the Plan to the contrary, the Plan shall be operated and maintained in a manner consistent with the Children's Health Insurance Program Reauthorization Act of 2009 (***CHIPRA***).

Mental Health Parity and Addiction Equity Act of 2008

Notwithstanding any provision of the Plan to the contrary, the Plan shall be operated and maintained in a manner consistent with the Mental Health Parity and Addiction Equity Act of 2008 (***MHPAEA***).

Michelle's Law

Notwithstanding any provision of the Plan to the contrary, the Plan shall be operated and maintained in a manner consistent with Michelle's Law (P.L. 110-381) solely to the extent such law is applicable to the Plan. This section shall be interpreted and applied to give only those rights as prescribed under Michelle's Law, and the rulings and regulations issued thereunder.

Affordable Care Act

To the extent the Plan is subject to the requirements of the Affordable Care Act, the Plan shall be operated and maintained in a manner consistent with its terms.

ARTICLE XI

MISCELLANEOUS

Recovery of Overpayments

If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan, the Participant or Dependent shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the Plan Administrator may recover that incorrect payment, whether or not it resulted from the Plan Administrator's own error, from the person to whom it was made or from any other appropriate party. As may be permitted in the sole discretion of the Plan Administrator, the refund or repayment may be made in one or a combination of the following methods: (1) in the form of a single lump-sum payment; (2) as a reduction of the amount of future benefits otherwise payable under the Plan; (3) as automatic deductions from pay; or (4) any other method as may be required or permitted in the sole discretion of the Plan Administrator. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party to the fullest extent permitted by applicable law.

Misrepresentation

Intentional misrepresentation of any material fact with respect to the Plan may result in termination of a Participant's eligibility to participate in the Plan.

Rescissions

The Plan Administrator may retroactively cancel or discontinue coverage under any component benefit program that is subject to the provisions of the Affordable Care Act upon thirty (30) days' notice if a Participant performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material facts. The Plan Administrator may also retroactively cancel or discontinue coverage under any component benefit program if the Participant fails to pay required premiums or contributions toward the cost of coverage.

Claims Litigation

If an individual's claim has been partially or completely denied, and the individual has exhausted all applicable internal and external claims and appeals procedures under the "*Claims Procedures*" section of the Plan or a component benefit program's relevant claims and appeals procedures, as applicable, the individual may bring an action under Section 502(a) of ERISA. However, no such legal action may be brought more than three (3) years following the date of the first decision on the claim.

No Contract of Employment

This Plan is not intended to be and shall not be construed as a contract of employment for any person.

No Vested Rights

No employee of an Employer, Participant, or Dependent shall at any time have any vested rights to benefits provided under the Plan or under any component benefit program.

Severability

If any provision of this Plan is held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and the Plan shall be construed and enforced as if such provision had not been included.

No Trust

To the extent any component benefit program is self-funded by the Employer, the benefits provided will be paid solely from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant in this Plan, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account, or asset of the Employer from which any self-funded benefit payment under the Plan may be made.

Governing Law

The Plan shall be governed and administered in accordance with ERISA and other applicable federal laws. If ERISA or other federal law requires or permits any provision of the Plan to be governed by or interpreted according to state law, the laws of the State of Alabama shall apply without regard to its conflicts-of-law principles.

Non-Alienation of Benefits

Benefits payable under the Plan shall not be subject to anticipation, alienation, sale, transfer, execution, or levy of any kind either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of the Participant, prior to actually being received by the person entitled to the benefit under the terms of the Plan. The Employer, Plan Administrator, and/or a third party claims administrator shall not in any manner be made liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits under the Plan.

No Guarantee of Tax Consequences

Notwithstanding any provision in the Plan to the contrary, neither the Plan nor the Employer make any commitment or guarantee that any amounts paid to or on behalf of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes. It shall be the obligation of each Participant to determine whether each payment is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

Subrogation and Reimbursement

The following provisions will apply to the subrogation and reimbursement rights of this Plan. The Plan has the right to full subrogation and reimbursement of any and all amounts paid by the Plan to, or on behalf of, an eligible Employee under the Plan, for which a third party is allegedly responsible. The Plan will have a lien against such funds, and the right to impose a constructive trust upon such funds, and will be reimbursed therefrom.

(a) The Plan's subrogation and reimbursement rights apply if the eligible Employee receives, or has a right to receive, any sum of money, regardless of whether it is characterized as amounts paid for

medical expenses or otherwise, paid or payable from any person, plan or legal entity that is legally obligated to make payments as a result of a judgment, settlement or otherwise, arising out of any act or omission of any third party (whether a third party or another eligible Employee under the Plan), (i) who is allegedly wholly or partially liable for costs or expenses incurred by the eligible Employee, in connection for which the Plan provided benefits to, or on behalf of, such eligible Employee or (ii) whose act or omission allegedly caused injury or illness to the eligible Employee, in connection for which the Plan provided benefits to, or on behalf of, such eligible Employee.

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

(c) The Plan has the right to be paid first and in full from any settlement or judgment, regardless of whether the eligible Employee has been "made whole." The Plan's right is a first priority lien. The Plan's right will continue until the eligible Employee's obligations hereunder to the Plan are fully discharged, even though the eligible Employee does not receive full compensation or recovery for his or her injuries, damages, loss, or debt.

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

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

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

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

(h) The Plan may withhold payment of benefits when a party other than the eligible Employee or the Plan may be liable for expenses until liability is legally determined. In the event that any payment is made under the Plan for which any party other than the eligible Employee or the Plan may be liable, the Plan will be subrogated to all rights of recovery of the eligible Employee to the extent of payments by the Plan and will have the right to be reimbursed.

(i) If an eligible Employee fails to comply with these requirements, the eligible Employee will not be eligible to receive any benefits, services, or payments under the Plan until there is compliance regardless of whether such benefits are related to the act or omission of such third party or other persons.

(j) Future Claims Excluded. If the eligible Employee receives any sum of money described in this section, the Plan will have no further obligation to pay benefits relating in any way to future claims for the same or related injuries, including but not limited to any complications thereof, for which the eligible Employee received such sum of money, and charges incurred for such services will be excluded.

Mistakes and Errors

It is recognized that in the administration of the Plan, certain administrative and accounting errors may be made or situations may arise by reason of factual errors in information supplied to the Employer or the Plan Administrator. The Employer and/or the Plan Administrator shall have the power to take such equitable steps as may be necessary to correct the mathematical, accounting or factual errors, as they, in their sole discretion, determine(s) to be appropriate.

No Assignment of Benefits

No benefit under this Plan, prior to its actual receipt, may be subject to any claim, debt, liability, contract, engagement, pledge, or tort, nor will such benefit be subject to anticipation, sale, assignment, attachment, lien, or other legal or equitable process unless provided otherwise pursuant to an Attachment; provided, however, amounts determined to be due and payable under the Plan may be directed by a Participant to a treatment provider furnishing services or supplies for which benefits are payable. In the case of treatments rendered by network providers, payment of benefits due under the Plan will be directed to the network providers consistent with their contractual arrangements. In no event will the Plan pay benefits in excess of the amount that would otherwise be payable in absence of any payment direction.

The fact that a payment has been directed to a provider shall not constitute an assignment of any rights, remedies or causes of action that a Participant has under this Plan or under any law that may relate to this Plan, such as ERISA. Such shall simply be regarded as a payment designation and payee direction.

Any assignment of rights, entitlements, and causes of action arising under ERISA or any other law or regulation is prohibited.

ARTICLE XII

GENERAL PLAN INFORMATION

Plan Name

Birmingham Southern College Welfare Benefits Plan

Plan Number

550

Plan Year

January 1 – December 31

Employer Information

Birmingham Southern College
900 Arkadelphia Road
Box 549090
Birmingham, AL 35254
(205) 226-4646

Plan Administrator Information

Birmingham Southern College
900 Arkadelphia Road
Box 549090
Birmingham, AL 35254
(205) 226-4646

Please note that the Insurers or Third Party Administrators are the claim fiduciaries for all benefits under the Plan/SPD which are provided through contracts of insurance. The name, address and phone number of the Insurers and Third Party Administrators are provided in Appendix A.

Plan Sponsor EIN

63-0288811

Type of Plan and Source of Funding

The Plan is an unfunded welfare benefit plan that includes medical, prescription drug, dental, vision, long term disability, and life insurance component benefits. Contributions are made by employees and the employer.

Type of Administration

The Plan includes fully insured benefits which are administered by the employer, a third-party claims administrator, or an insurance company.

Agent for Service of Legal Process

Birmingham Southern College
900 Arkadelphia Road
Box 549090
Birmingham, AL 35254
(205) 226-4646

Service of legal process also may be made on the Plan Sponsor.

IN WITNESS WHEREOF, Birmingham Southern College has caused this Plan to be signed by its duly authorized officer as of this 1 day of January, 2018.

BIRMINGHAM SOUTHERN COLLEGE

By: _____

Its: Associate VP HR

APPENDIX A

Available Benefits

Program/Benefits	Third Party Administrator/ Insurer	Address	Contract or Policy Number	Funding
Medical PPO Plan Option I **ATTACHMENT A**	Blue Cross and Blue Shield of Alabama	450 Riverchase Parkway East P.O. Box 995 Birmingham, AL35298-0001	75450/000	Insured
Medical PPO Plan Option II **ATTACHMENT B**	Blue Cross and Blue Shield of Alabama	450 Riverchase Parkway East P.O. Box 995 Birmingham, AL35298-0001	75450/002	Insured
Medical HDHP 2500 Plan (HSA Banking) **ATTACHMENT C**	Blue Cross and Blue Shield of Alabama	450 Riverchase Parkway East P.O. Box 995 Birmingham, AL35298-0001	75452/000	Insured
Medical HDHP 2500 Plan (HSA Non-Banking) **ATTACHMENT D**	Blue Cross and Blue Shield of Alabama	450 Riverchase Parkway East P.O. Box 995 Birmingham, AL35298-0001	76446/000	Insured
Dental Coverage Basic and Buy-Up Plans **ATTACHMENT E**	Delta Dental Insurance Company	1130 Sanctuary Parkway Suite 600 Alpharetta, GA 30009	10423	Insured
Vision **ATTACHMENT F**	Vision Service Plan Insurance Company	3333 Quality Drive Rancho Cordova, CA 95670	30061812	Insured
Long Term Disability **ATTACHMENT G**	United of Omaha Life Insurance Company	Mutual of Omaha Plaza Omaha, Nebraska 68175	GUPR-AYN9	Insured
Group Term Life Insurance and AD&D **ATTACHMENT H**	United of Omaha Life Insurance Company	Mutual of Omaha Plaza Omaha, Nebraska 68175	GLUG-AYN9	Insured
Voluntary Term Life Insurance and AD&D **ATTACHMENT I**	United of Omaha Life Insurance Company	Mutual of Omaha Plaza Omaha, Nebraska 68175	GVTL-AYN9	Insured
Flexible spending and limited flexible spending components of the Birmingham Southern Cafeteria Plan **ATTACHMENT J**				