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# UNIVERSITY OF DELAWARE GROUP HEALTH INSURANCE PLAN

# (EFFECTIVE AS OF JULY 1, 2025)

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# UNIVERSITY OF DELAWARE GROUP HEALTH INSURANCE PLAN

## (EFFECTIVE AS OF JULY 1, 2025)

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# UNIVERSITY OF DELAWARE GROUP HEALTH INSURANCE PLAN

## (EFFECTIVE AS OF JULY 1, 2025)

## Introduction

The University of Delaware (the "University") hereby establishes the University of Delaware Group Health Insurance Plan (the "Plan"), which consists of various employee health and welfare benefit programs established for the exclusive benefit of its Eligible Employees and such Eligible Employees' Dependents (each a "Component Plan"), effective as of July 1, 2025.

The Plan is intended to comply with all relevant provisions of all applicable federal and state law, including the Code, and shall be interpreted in a manner consistent with the requirements of such laws. The University is a subdivision, agency or instrumentality of the State of Delaware and this Plan is a "governmental plan" exempt from the Employee Retirement Income Security Act. Though the effective date of the Plan is July 1, 2025, the Plan incorporates certain health and welfare benefit programs that constitute Component Plans, which existed prior to such date. Certain other health and welfare benefit programs which constitute Component Plans were previously made available to Eligible Employees through the State of Delaware Group Health Insurance Plan, sponsored and maintained by the State of Delaware (the "GHIP"). The University withdrew from the GHIP effective June 30, 2025. The Plan consists of this document and the Incorporated Documents.

In the event that a provision of an Incorporated Document conflicts with a provision of this Plan document or any other Incorporated Document, the Plan Administrator or Committee, as applicable, shall, in its discretion, interpret the terms and purpose of the Plan so as to resolve any conflict. However, the terms of this Plan document may not increase the rights or benefits of an Eligible Employee or such Eligible Employees' Dependents to benefits available under any Component Plan. If there is no provision in an applicable Incorporated Document corresponding to a provision of the Plan, to the extent applicable, the provisions of this Plan document apply to the Component Plan. If a provision in an applicable Incorporated Document is legally insufficient, the applicable provisions of the Plan apply to the Component Plan to the extent deemed necessary by the Plan Administrator or Committee.

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## DEFINITIONS

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

### 1.1 Affiliate

An entity that is, directly or indirectly, controlled by, or under common control with, the University in accordance with the principles of Code Sections 414(b) and 414(c), as interpreted by the Internal Revenue Service for purposes of tax-exempt entities. An entity is an Affiliate only while a member of such group.

### 1.2 Beneficiary

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

### 1.3 Benefit

Any benefit provided pursuant to any Component Plan.

### 1.4 Claimant

An individual who makes an Eligibility or Enrollment Claim or a claim for Benefits under a Component Plan.

### 1.5 Claims Administrator

Any individual, committee, third party administrator or insurance company designated by the University or the Committee to review and process claims for benefits under a Component Plan.

### 1.6 COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, along with amendments to such law and any pertinent regulations, rulings, notices or other promulgations thereunder.

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### 1.7 COBRA Continuation Coverage

Continuation of coverage elected under COBRA.

### 1.8 Code

The Internal Revenue Code of 1986, as amended from time to time, and the regulations thereunder.

### 1.9 Committee

Means the University of Delaware Health & Welfare Plan Oversight Committee established by the University to review and decide Eligible Employee, Dependent, Beneficiary, and provider appeals related to the Plan and to carry out the other duties and responsibilities delegated to it by the University pursuant to this Plan document and the Committee's charter.

### 1.10 Component Plans

The specific arrangements or programs by which the Plan provides certain types of benefits. A Component Plan may be amended from time to time as specified in such Component Plan or by the Plan Administrator. The term "Component Plan" shall not include any voluntary group insurance program that is made available through the University and is paid for solely by the electing employee. A Component Plan may become a part of the Plan either before or after execution of this document by reference in an applicable Incorporated Document to Plan No. 501 without the execution of any other instrument. The Component Plans are listed on Exhibit A hereto.

### 1.11 Covered Person

The Participant, Dependent or anyone who is covered under this Plan.

### 1.12 Dependent

An individual eligible for coverage as a dependent of an Eligible Employee under one or more Component Plans maintained under the Plan. The eligibility rules for any Component Plan are set forth in the applicable Incorporated Documents.

### 1.13 Eligibility or Enrollment Claim

A claim as to whether an individual is eligible to participate in or obtain coverage under, or whether an eligible individual is enrolled for participation in or coverage under, a Component Plan or applicable Component Plan option, made in accordance with the Component Plan's procedures for filing eligibility or enrollment claims.

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### 1.14 Eligible Employee

Any individual who is classified by the University as a common law employee or former common law employee (regardless of retroactive reclassification for any purpose) of the University who is eligible to participate in and receive benefits under one or more of the Component Plans under the Plan. An employee's ability to receive benefits under the Plan is dictated by and limited to the employee's eligibility to receive benefits under the applicable Component Plan. The eligibility rules for any Component Plan are set forth in the applicable Incorporated Documents.

### 1.15 Eligible Retiree

Any individual who is eligible to participate in and receive benefits (other than COBRA Continuation Coverage) under one or more of the Component Plans by reason of incurring a termination of service with the University.

### 1.16 FMLA

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

### 1.17 HIPAA

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

### 1.18 Incorporated Documents

With respect to a Component Plan, the plan documents, summary plan descriptions, benefits summaries, Insurance Contracts or other documents governing such Component Plan, and which are described in Exhibit A, including any and all attachments, amendments and supplements thereto, as well as any documents incorporated by reference into such plan documents, summary plan descriptions, Insurance Contracts or other documents, including, without limitation, applications and certificate of insurance booklets.

### 1.19 Insurance Contract

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

### 1.20 Insured Component Plan

A Component Plan funded pursuant to an Insurance Contract.

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### 1.21 Leave of Absence or Leave

Any paid or unpaid leave from active employment duly authorized by the University under its standard personnel practices. Such term shall also include any paid or unpaid leave from active employment duly authorized by the University under the Family and Medical Leave Act of 1993 or the Uniformed Services Employment and Reemployment Rights Act of 1994.

### 1.22 Participant

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

### 1.23 Plan

The University of Delaware Group Health Insurance Plan as set forth herein, together with any and all amendments and supplements hereto, and including the provisions of all Incorporated Documents governing the Component Plans pursuant to which Benefits are provided from time to time. Solely for purposes of Code Sections 105(h) and 125, each Component Plan shall be treated as a separate plan, and any two or more Component Plans may be aggregated for purposes of Code Sections 105(h) and 125 to the extent permitted thereunder.

### 1.24 Plan Administrator

The Committee.

### 1.25 Plan Year

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

### 1.26 PPACA

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

### 1.27 Self-Funded Component Plan

A Component Plan funded through any method other than an Insurance Contract.

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**1.28 Spouse**

A person to whom an Eligible Employee is legally married (as determined under applicable state law at the time and location where the marriage ceremony was performed).

**1.29 USERRA**

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

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# ARTICLE II
# PARTICIPATION

## 2.1 Commencement of Participation

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

The classifications of Eligible Employees, Eligible Retirees, and Dependents, the requirements for participation, the requirements for continuation of participation, and the events giving rise to termination of participation under any Component Plan shall be as provided for in the applicable Incorporated Documents.

## 2.2 Dual Coverage Rule

Unless otherwise provided by the applicable Component Plan:

(a) no individual may be a Dependent of more than one Employee for purposes of eligibility to participate in the Plan and the Component Plans; and

(b) no individual may be covered as both an Employee and as a Dependent of another Employee for purposes of participation in the Plan and the Component Plans.

## 2.3 Cessation of Participant's Participation

(a) **Effective Date of Termination**: A Participant's participation and coverage (and that of the Participant's eligible Dependents) cease as of the earliest of:

(1) the date on which the Plan is terminated;

(2) the date on which the Participant ceases to be an Eligible Employee or Eligible Retiree under each Component Plan in which such Participant is eligible to participate, and the Participant's benefit coverage expires as set forth in such Component Plans;

(3) the end of the period for which the Participant made the last required contribution under all Component Plans; and

(4) the effective date of the Participant's cancellation of coverage under each Component Plan in which such Participant is eligible to participate.

(b) **Availability of Continued Coverage**: Notwithstanding any other provision of this Section to the contrary, a Participant who takes a Leave of Absence may continue as a Participant during such authorized absence in accordance with, and subject to, the Plan Administrator's rules and regulations. In addition, qualified beneficiaries as defined under COBRA are entitled to enroll in COBRA

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Continuation Coverage under certain Component Plans as described in Section 2.5.

(c) **No Rescissions**: Notwithstanding any other provision of this Section to the contrary, the cessation of a Participant's participation and coverage (and that of the Participant's eligible Dependents) under any medical plan will comply with the requirements of Section 2712 of the Public Health Service Act (regarding restrictions on rescissions), in accordance with rules and procedures established by the Plan Administrator or its delegate.

## 2.4 Cessation of Dependent's Participation

(a) **Effective Date of Termination**: An eligible covered Dependent's participation and coverage cease as of the earliest of:

(1) the date on which the Participant's coverage under the Plan ends;

(2) the date such Dependent ceases to be an eligible Dependent under each Component Plan in which such Dependent is eligible to participate and the Dependent's benefit coverage expires as set forth in such Component Plans;

(3) the end of the period for which the Participant made the last required contribution for the Dependent's coverage under all Component Plans; and

(4) the effective date of the Participant's cancellation of coverage for the Dependent under each Component Plan in which such Dependent is eligible to participate.

(b) **No Rescissions**: Notwithstanding any other provision of this Section to the contrary, the cessation of a covered Dependent's participation and coverage under any medical plan will comply with the requirements of Section 2712 of the Public Health Service Act (regarding restrictions on rescissions), in accordance with rules and procedures established by the Plan Administrator or its delegate.

## 2.5 COBRA Continuation Coverage

With respect to each Component Plan that is subject to COBRA, Covered Persons who are qualified beneficiaries, as defined in Code Section 4980B(g)(1) will be given the option of electing COBRA Continuation Coverage.

## 2.6 Reinstatement of Former Participants

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

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## 2.7 Participation during Leaves of Absence under the FMLA

Notwithstanding any other provision of the Plan to the contrary, a Participant who is on Leave under the FMLA may continue participation in the Plan for up to 12 weeks (or up to 26 weeks in the case of military caregiver leave under the FMLA). Such participation is provided under the terms and conditions of the Plan and the Component Plans (including rate of contributions) that would have been provided if the Participant had continued employment and is subject to the terms and conditions of the University's policies regarding paid and unpaid leaves of absence under the FMLA.

## 2.8 Participation during Periods of Qualified Military Service under USERRA

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

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# ARTICLE III
# BENEFITS AVAILABLE

## 3.1 Description of Benefits

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

## 3.2 Incorporated Documents

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

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# ARTICLE IV
# FUNDING OF BENEFITS

## 4.1 Funding of Benefits

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

## 4.2 Limitation of University Liability

Benefits funded pursuant to Insurance Contracts shall be paid solely by the respective insurance carriers thereunder. The University does not have any liability for any Benefits due, or alleged to be due, under any applicable Insurance Contract. To the extent certain Benefits under a Component Plan are self-insured by the University, the Benefits may be paid solely from the general assets of the University. Nothing herein may be construed to require the University or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant in the Plan or such Participant's Dependents, and no Participant, Dependent or other person has any claim against, right to or security or other interest in, any fund, account or asset of the University from which any self-insured benefit payment under the Plan may be made.

## 4.3 Participant Contributions

Each Participant or other Covered Person under any Component Plan shall make such contributions as the University may require with respect to Benefits available to the Participant or other Covered Person under a Component Plan. The University may initiate, or change the amount of, required Participant contributions for any coverage level under any Component Plan at any time. Where applicable, required Participant contributions for coverage under a particular Component Plan may be paid by a Participant either through pre-tax pay deduction pursuant to Section 125 of the Code or through after-tax pay deduction, whichever is specified under the Component Plan by the University or Plan Administrator.

## 4.4 University Contributions

The University shall make contributions in such amounts and at such times as the University shall from time to time determine, pursuant to any policy or method that the University may establish in its sole discretion.

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### 4.5 Priority of Contributions

The University shall determine, in its sole discretion, the order in which contributions by Participants and other Covered Persons and University contributions shall be applied to fund Benefits, insurance premiums, administrative expenses and other costs of the Plan.

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# ARTICLE V
# ADMINISTRATION

## 5.1 The University's Responsibilities

The University in its capacity as employer shall have overall discretionary responsibility for the establishment, amendment and termination of the Plan. All such responsibilities of the University as employer under the Plan shall be carried out by the appropriate officer of the University or such officer's delegate.

## 5.2 Plan Administrator

(a) **General**: The Plan Administrator is the general administrator of the Plan and has the discretionary responsibility for the operation and administration of the Plan, including, but not limited to, those powers and duties set forth in Subsection (b) of this Section. The Plan Administrator may appoint such agents as it may deem necessary for the effective performance of its duties, and may delegate to such agents such powers and authority, whether ministerial or discretionary, as the Plan Administrator may deem expedient or appropriate. As applicable, any reference to Plan Administrator shall include its delegate including, without limitation, the carrier for an Insured Component Plan. Responsibilities of the Plan Administrator under the Plan shall be carried out by the carriers under any Insurance Contracts, any third-party administrators appointed by the University or Plan Administrator and any special committees or other persons appointed by the University or Plan Administrator, as provided for in this Plan document and the applicable Incorporated Documents governing each Component Plan, and as determined by the Plan Administrator. The compensation of such agents is fixed by the Plan Administrator within any limits set by the University.

(b) **Powers of the Plan Administrator**: The Plan Administrator has discretionary authority and control, and all powers necessary or desirable to, control and manage the operation and administration of the Plan. The Plan Administrator has full discretionary power to administer the Plan in all of its details, subject to applicable requirements of law. To the extent the Plan Administrator delegates to one or more Claims Administrators authority to make claims determinations, such Claims Administrator has the same discretion as the Plan Administrator. In addition to any powers and authority expressly conferred upon the Plan Administrator elsewhere in the Plan, the Plan Administrator shall have, by way of illustration and not by way of limitation, the following discretionary and final authority to:

(1) adopt amendments to the Plan and any Component Plan which are required by a change in law or as otherwise necessary or desirable;

(2) make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan and any Component Plan, including the establishment of any claims procedures that may be

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required by applicable provisions of law, provided that all rules, regulations and decisions of the Plan Administrator must be uniformly and consistently applied to all persons in similar circumstances;

(3) construe and interpret the provisions of the Plan and any Component Plan (and the rules, procedures, forms and other documentation that it has created or approved for the Plan and any Component Plan), including, without limitation, by supplying omissions from, correcting deficiencies in, or resolving inconsistencies or ambiguities in, the language of the Plan and any Component Plan and consistent with the intent of the Plan or such Component Plan;

(4) decide all questions concerning the Plan and any Component Plan, including, without limitation, factual questions and the eligibility of any person to participate in the Plan and any Component Plan;

(5) compute the amount of benefits payable to any Participant, Dependent or other person in accordance with the provisions of the Plan and any Component Plan, and to determine the person or persons to whom such benefits are paid;

(6) authorize the payment of benefits;

(7) make any equitable adjustments to correct any error or omission discovered in the administration of any Component Plan;

(8) require Participants to furnish such information as the Plan Administrator may require for the purpose of the proper administration of the Plan or any Component Plan as a condition to receiving benefits under the Plan or such Component Plan;

(9) cause the Plan and any Component Plan to be administered in accordance with its terms;

(10) make or approve rules, procedures, forms and other documentation for the administration and operation of the Plan and the Component Plans;

(11) keep and maintain all records, books of accounts, data and documents that are necessary for the proper administration of the Plan and the Component Plans;

(12) cause all required information to be disclosed to Participants and Beneficiaries concerning the Plan and the Component Plans;

(13) select and designate the named fiduciaries of the Plan and the Component Plans and other service providers with respect to the Plan and the Component Plans, including trustees and agents as appropriate under the Plan and Component Plan;

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(14) monitor the general administration and maintenance of the Plan and any Component Plan, including legal and regulatory compliance;

(15) cause all required reports, returns and documents for the Plan and any Component Plan to be filed with the appropriate governmental entities, as applicable;

(16) appoint such agents, attorneys, accountants or other parties who need not be employees of the University or its affiliates, as it may deem necessary for the effective performance of its duties, and the Plan Administrator may delegate to those agents, attorneys, accountants or other parties the powers and duties, whether ministerial or discretionary, that the Plan Administrator may deem expedient or appropriate;

(17) create subcommittees of its members with such powers as it shall determine, which subcommittees may further delegate such duties to the extent not prohibited by the Plan Administrator, and which subcommittees shall report on their activities to the Plan Administrator from time to time in such manner as the Plan Administrator determines;

(18) designate and allocate any responsibility to any other person or persons, including employees of the University or its Affiliates, with such powers as it shall determine, which persons may further delegate such duties to the extent not prohibited by the Plan Administrator, and who shall report on their activities to the Plan Administrator from time to time in such manner as the Plan Administrator determines; and

(19) carry out any other duties provided by any Plan document and exercise such other specific powers, authority and discretion as are expressly or by necessary implication conferred upon it.

Any determination by the Plan Administrator or its authorized delegate is final and binding on all persons and entitled to the maximum deference allowed by law.

In the case of any inconsistency between the provisions of this Plan and the provisions of any Incorporated Documents governing the Component Plans maintained under this Plan, the provisions of this Plan shall govern.

### 5.3 Claims Administrators

Notwithstanding anything in this Plan to the contrary, a Claims Administrator who has been delegated the authority and duty to make final determinations on appeals of denied Benefit claims, shall have the full discretionary authority to interpret and construe the terms of the applicable Insurance Contracts and other Incorporated Documents and to make final and binding determinations of claims for Benefits under such contracts and other Incorporated Documents with respect to the Component Plan. Any determination made in good faith by such Claims Administrator shall be conclusive and binding upon

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Employees, Participants and their Beneficiaries and Dependents, including any parties who appeal denied benefit claims to the Claims Administrator. To the extent permitted under applicable law, any determination made by the Claims Administrator shall be given deference, and if it is subject to judicial review, shall be overturned only if it is arbitrary or capricious. Notwithstanding the foregoing, Eligibility or Enrollment Claims are determined by the Plan Administrator, or its designee, and review of denied determinations on Eligibility or Enrollment Claims are determined by the Plan Administrator or its duly authorized delegate, all in accordance with the claims procedures applicable to this Plan.

## 5.4 Coordination of Benefits

The Component Plans may contain special procedures for coordinating benefits when a Covered Person has group health coverage (including medical, prescription drug, dental and vision coverage) under two or more plans. The coordination of benefits procedures to be followed by Covered Persons to obtain payment of benefits under this Plan shall be in accordance with the rules and procedures set forth in the Component Plans and applicable law.

## 5.5 Books and Records

The Plan Administrator shall keep such books, records and other data as it deems necessary for proper administration of the Plan. The records of the Plan Administrator shall be binding on all persons unless proved incorrect to the satisfaction of the Plan Administrator.

## 5.6 Reliance by Plan Administrator

(a) **Reliance on Tables, Etc.**: In administering the Plan and any Component Plan, the Plan Administrator is entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by, or in accordance with the instructions or recommendations of, any delegee described in Section 5.2(b), or by any other experts employed or engaged by the Plan Administrator.

(b) **Reliance on Participant's or Dependent's Certifications**: The Plan Administrator is entitled to rely conclusively on certifications and information provided by the Participant or the Participant's Dependent, unless the Plan Administrator has reason to believe that the Participant's or Dependent's certification or other information provided is incorrect.

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# ARTICLE VI
# CLAIMS AND REVIEW PROCEDURES

## 6.1 General

(a) **Provisions Governing Claims Procedures**: The claims procedure for each Component Plan shall be governed by the applicable Incorporated Documents. To the extent that an Incorporated Document governing such Component Plan does not specifically address the claims procedure or is contrary to applicable laws, the following procedural provisions shall control, unless applicable state law provides for more stringent requirements.

(b) **No Designation of Claims Administrator**: If there has not been any designation of a Claims Administrator with respect to a Component Plan, all references to the Claims Administrator in this Article are deemed references to the Plan Administrator. The Claims Administrators are listed on Exhibit A.

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

## 6.2 Claims Procedures for Determinations of Disability

(a) **Initial Claim**

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

(A) **Notification of Claim Denial**: If a claim for benefits is denied, in whole or in part, the Claimant will receive a written notice from the Claims Administrator within a reasonable period of time, but no later than 45 days after it receives the claim in accordance with

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its reasonable procedures. Under special circumstances, the Claims Administrator may take up to an additional 30 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the Claimant will be notified before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that an additional extension is necessary due to matters beyond its control, the Claims Administrator may take up to an additional 30 days to review the claim. If an additional extension of time is required, the Claimant will be notified before the end of the initial 30-day extension period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If the Claims Administrator extends its period for reviewing a claim due to special circumstances, the notice of extension the Claimant receives will include an explanation of the standards on which entitlement to benefits is based, the unresolved issues that prevent a decision on the claim and any additional information needed to resolve these issues. The Claimant has at least 45 days to provide the specified information. In the event that a period of time is extended due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which notification of an extension is sent to the claimant until the date on which the Claimant responds to the request for information.

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

(i) the specific reason or reasons for the adverse determination;

(ii) references to the specific Component Plan provisions on which the determination is based;

(iii) a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) a description of the Component Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action following an adverse benefit determination on review;

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(v) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Component Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Component Plan do not exist;

(vi) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Component Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(vii) a discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by the Claimant to the Component Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Component Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination and (c) a disability determination regarding the Claimant presented by the Claimant to the Component Plan and made by the Social Security Administration; and

(viii) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits.

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

(b) **Appeals**

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

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(A) the reasons why the Claimant feels the claim is valid; and

(B) the reasons why the Claimant thinks the claim should not be denied.

Documents, records, written comments, and other information in support of the appeal should accompany the request. This information will be considered by the Claims Administrator in reviewing the claim. The Claimant may request to examine and receive copies of all documents, records, and other information relevant to the claim. All claims and appeals for disability benefits must be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. The Claims Administrator will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon or generated by the Component Plan, Insurer or other person making the benefit determination (or at the direction of the Component Plan, Insurer or such other person) in connection with the Claimant's appeal as soon as possible and sufficiently in advance of the date on which it provides the Claimant with notice of its determination on appeal, so that the Claimant will have a reasonable opportunity to respond prior to that date. In addition, if the denial of the Claimant's appeal is based on a new or additional rationale, the Claims Administrator will provide the Claimant, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides the Claimant with notice of its determination on appeal, so that the Claimant will have a reasonable opportunity to respond prior to that date.

(2) **Notification of Appeal Decision**: The Claims Administrator will notify the Claimant of its decision on the appeal within 45 days after receipt of the appeal. Under special circumstances, the Claims Administrator may take up to an additional 45 days to review the appeal if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the Claimant will be notified in writing before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. The Claimant has at least 45 days to provide the specified information.

(3) **Content of Notification of Appeal Decision**: If the appeal is denied, in whole or in part, the Claims Administrator will notify the Claimant in writing. The notice will include:

(A) the specific reason or reasons for the adverse determination;

(B) reference to the specific Component Plan provisions on which the benefit determination is based;

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(C) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits;

(D) a statement describing any voluntary appeal procedures offered by the Component Plan and the Claimant's right to obtain information about those procedures;

(E) a statement about the Claimant's right to bring a civil action and any applicable contractual limitations period that applies to the Claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires;

(F) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Component Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Component Plan do not exist;

(G) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Component Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(H) a discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) the views presented by the Claimant to the Component Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Component Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination and (iii) a disability determination regarding the Claimant presented by the Claimant to the Component Plan and made by the Social Security Administration.

Any such notice of an adverse benefit determination will be provided in a culturally and linguistically appropriate manner. In addition, upon request, the Claims Administrator will provide the Claimant with a

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statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.

**6.3 Claims Procedures for Group Health Plans**

(a) **Initial Claim**

(1) **Urgent Care Claims**

(A) **Timing of Decision**: In the case of a claim involving urgent care under a Component Plan providing group health benefits, the Claims Administrator will review the claim and inform the Claimant in writing of its decision (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after it receives the claim.

(B) **Additional Information**: If the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Component Plan, the Claims Administrator will inform the Claimant as soon as possible, but no later than 24 hours after it receives the claim, of the specific information necessary to complete the claim. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but no less than 48 hours, to provide the specified information. The Claims Administrator will notify the Claimant of its benefit determination as soon as possible, and no later than 48 hours after the earlier of:

(i) the Claims Administrator's receipt of the specified information; and

(ii) the end of the period afforded to the Claimant to provide the specified additional information.

(C) **Urgent Care Claim Defined**: For purposes of this Article, a "claim involving urgent care" is any claim for medical care or treatment with respect to which the application of time periods for making non-urgent care determinations:

(i) could seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function; or

(ii) in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

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(2) **Pre-Service Claims**

(A) **Timing of Decision**: In the case of a pre-service claim under a Component Plan providing group health benefits, the Claims Administrator will inform the Claimant of its decision (whether adverse or not) within a reasonable period of time appropriate to the medical condition, but not later than 15 days after it receives the claim. Under special circumstances, the Claims Administrator may take up to an additional 15 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the Claimant will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

(B) **Additional Information**: If the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Component Plan, the Claims Administrator will inform the Claimant as soon as possible, but no later than 5 days after it receives the claim, of the specific information necessary to complete the claim. The Claimant must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends a notice of missing information and the determination period will resume on the date the Claimant responds to the notice.

(C) **Pre-Service Claim Defined**: For purposes of this Article, "pre-service claim" means any claim for a benefit under the Component Plan with respect to which the terms of the Component Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(3) **Post-Service Claims**

(A) **Timing of Decision**: In the case of a post-service claim under a Component Plan providing group health benefits, the Claims Administrator will inform the Claimant of its decision within a reasonable period of time, but not later than 30 days after it receives the claim. Under special circumstances, the Claims Administrator may take up to an additional 15 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the Claimant will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

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(B) **Additional Information**: If the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Component Plan, the Claims Administrator will inform the Claimant as soon as possible, but no later than 30 days after it receives the claim, of the specific information necessary to complete the claim. The Claimant must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends a notice of missing information and the determination period will resume on the date the Claimant responds to the notice.

(C) **Post-Service Claim Defined**: The term "post-service claim" means any claim for a benefit under a Component Plan that is not a pre-service claim or an urgent care claim.

(4) **Concurrent Care Decisions**

(A) **Timing of Decision**: If a Component Plan providing group health benefits has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Component Plan of the course of treatment (other than by plan amendment or termination) before the end of the previously approved period of time or number of treatments will constitute a claim denial. If this occurs, the Claims Administrator will notify the Claimant of its decision at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a decision on appeal before the benefit is reduced or terminated.

(B) **Special Rules for Urgent Care Claims**: Any request by the Claimant to extend the course of treatment beyond the previously approved period of time or number of treatments that constitutes a claim involving urgent care will be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator will inform the Claimant of its decision (whether adverse or not) within 24 hours after it receives the claim, provided that the claim is made to the Claims Administrator at least 24 hours before the expiration of the prescribed period of time or number of treatments.

(5) **Notice of Extension**: If the Claims Administrator extends its period for reviewing a claim due to special circumstances as described in this Subsection, the notice of extension that the Claimant receives will include:

(A) an explanation of the standards on which entitlement to benefits is based;

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(B) the unresolved issues that prevent a decision on the claim; and

(C) any additional information needed to resolve those issues.

(6) **Content of Notification of Denial**: The Claimant will be notified in writing if any part of a claim for benefits under a Component Plan providing group health benefits is denied. This notice will include:

(A) the specific reason or reasons for the denial;

(B) specific references to the pertinent Plan provisions on which the denial is based;

(C) a description of any additional information or materials necessary to process the claim properly and the reasons why the materials are needed;

(D) a description of the Plan's internal claims review process and the time limits applicable to such process (including, with respect to the University's medical plan, the external review process), including a statement of the Claimant's right to bring a civil action following an adverse benefit determination on review;

(E) a statement that a copy of any internal rule, guideline, protocol or other similar criteria relied upon in making the adverse benefit determination is available free of charge upon request;

(F) a statement that if a denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limit, the Claims Administrator will, upon request, provide the Claimant, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical circumstances;

(G) in the case of a denial concerning a claim involving urgent care, a description of the expedited review process applicable to such claims; and

(H) with respect to the University's medical plan, the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist the claimant with the internal claims and appeals and external review process:

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

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(b) **Appeals**

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

(A) the reasons why the Claimant feels the claim is valid; and

(B) the reasons why the Claimant thinks the claim should not be denied.

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

(2) **Review of Appeal**: Any information provided by the Claimant in connection with the appeal will be considered by the Claims Administrator or Plan Administrator, as applicable, in reviewing the claim. The Claims Administrator or Plan Administrator, as applicable, will review the appeal without granting any deference to the initial decision regarding the claim. Also, no reviewer may be a person who was involved in making the initial decision regarding the claim, or a subordinate to that person. In addition, if the denial of the claim was based, in whole or in part, on a medical judgment in reviewing the claim, the Claims Administrator or Plan Administrator, as applicable, will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment in reviewing the claim. This person will not be a person or a subordinate of a person consulted by the Claims Administrator or Plan Administrator, as applicable, in deciding the initial claim.

(3) **Appeal of a Medical Plan Claim**: With respect to the University's medical plan, the Claimant will be allowed to review the claim file and to provide evidence and testimony as part of the internal claims and appeals process. The applicable Claims Administrator or Plan Administrator, as applicable, will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon or generated by the plan (or at the direction of the medical plan) in connection with the Claimant's appeal as soon as possible and sufficiently in advance of the date on which it

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provides the Claimant with notice of its determination on appeal, so that the Claimant will have a reasonable opportunity to respond prior to that date. In addition, if the denial of the Claimant's appeal is based on a new or additional rationale, the applicable Claims Administrator or Plan Administrator, as applicable, will provide the Claimant, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides the Claimant with notice of its determination on appeal, so that the Claimant will have a reasonable opportunity to respond prior to that date.

(4) **Notification of Appeal Decision**

(A) **Urgent Care Claims**: In the case of a claim involving urgent care, the Claims Administrator or Plan Administrator, as applicable, will provide this notice as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the request for review.

(B) **Pre-Service Claims**: In the case of a pre-service claim, the Claims Administrator or Plan Administrator, as applicable, will provide this notice within a reasonable amount of time appropriate to the medical circumstances but not later than 30 days after receipt of the request for review if the Component Plan provides for only one mandatory appeal of an adverse benefit determination or within 15 days for each appeal if the Component Plan provides for two mandatory appeals of an adverse determination.

(C) **Post-Service Claims**: In the case of a post-service claim, the Claims Administrator or Plan Administrator, as applicable, will provide this notice within a reasonable amount of time but not later than 60 days after receipt of the request for review if the Component Plan provides for only one mandatory appeal of an adverse benefit determination or within 30 days for each appeal if the Component Plan provides for two mandatory appeals of an adverse determination.

(D) **Concurrent Care Claims**: In the case of a concurrent care claim, the Claims Administrator or Plan Administrator, as applicable, will provide this notice within a reasonable amount of time appropriate to the medical circumstances but not later than 15 days after receipt of the request for review for each level of the Claimant's appeal.

(5) **Content of Appeal Denial**: The notice provided for all appeal denials under a Component Plan providing group health benefits will include:

(A) the specific reason or reasons for the denial;

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(B) specific references to the pertinent Plan provisions on which the denial is based;

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

(D) a statement about the Claimant's right to bring a civil action following any final internal adverse benefit determination;

(E) a statement that a copy of any internal rule, guideline, protocol or other similar criteria relied upon in making the adverse benefit determination is available free of charge upon request;

(F) a statement that if a denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limit, the Claims Administrator or Plan Administrator, as applicable, will, upon request, provide the Claimant, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical circumstances; and

(G) with respect to the University's medical plan, notice of the right to receive the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist the Claimant with the internal claims and appeals and external review process.

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

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

(6) **Medical Plan External Review Process**: For adverse determinations related to the University's medical plan (other than adverse determinations relating to a determination that a claimant fails to meet the requirements for eligibility under the terms of such plan), the Claimant will have the right to an external review process. In general, Claimants are entitled to this external review process once the internal claims and appeals procedures have been fully exhausted. Claimants will be deemed to have fully exhausted the internal claims and appeals process when the Claims Administrator or Plan Administrator fails to strictly adhere to the

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requirements for internal claims and appeals, except where such failure is minor, de minimis, non-prejudicial, attributable to good cause or matters beyond the Plan's control, in the context of an ongoing good-faith exchange of information, not reflective of a pattern or practice of non-compliance, or such other exceptions as may be provided in guidance issued under the Patient Protection and Affordable Care Act of 2010. Further, Claimants are entitled to an expedited external review process if: (i) the adverse benefit determination involves a medical condition for which the timeframe for internal appeal described herein would seriously jeopardize the Claimant's life or health or would jeopardize the Claimants ability to regain maximum function and the Claimant has filed a request for expedited internal review as described herein; or (ii) the Claimant has received a final adverse benefit determination and the standard external review would seriously jeopardize the Claimant's life or health, would jeopardize the Claimant's ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the Claimant has received emergency services, but has not been discharged from a facility.

In the case of the University's medical plan, any external review will be conducted in accordance with the requirements of the Patient Protection and Affordable Care Act of 2010 and any regulations or guidance issued thereunder. The external review procedure shall be described in the summary plan description applicable to the University's medical plan.

### 6.4 Claims Procedures for Other Plans, Eligibility or Enrollment

(a) **Initial Claim**: To receive or apply for benefits under any Component Plan not specifically described in Sections 6.3 or 6.4, or with respect to any Eligibility or Enrollment Claim, the Claimant must submit initial claims and/or appeals, as applicable, in accordance with this Section.

(1) **Notification of Claim Denial**: If the claim for benefits is denied, in whole or in part, the Claimant will receive a written notice from the Claims Administrator within 90 days. Under special circumstances, the Claims Administrator may take up to an additional 90 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the Claimant will be notified before the end of the initial 90-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If a Claimant does not receive a response within 90 days, the claim is treated as denied.

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

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(A) the specific reason or reasons for the denial;

(B) specific references to the pertinent Plan provisions on which the denial is based;

(C) a description of any additional information or materials necessary to perfect the claim and an explanation of why such material or information is needed; and

(D) an explanation of the claims review process and the time limits applicable to such process, including a statement of the Claimant's right to bring a civil action following an adverse benefit determination on review.

(b) **Appeals**

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

(A) the reasons why the Claimant feels the claim is valid; and

(B) the reasons why the Claimant thinks the claim should not be denied.

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

(2) **Notification of Appeal Decision**: The Claims Administrator will review the appeal and inform the Claimant in writing of its decision within a reasonable period of time, but no later than 60 days after it receives the appeal. Under special circumstances, the Claims Administrator may take up to an additional 60 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the Claimant will be notified before the end of the initial 60-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

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(3) **Content of Appeal Denial**: If the claim is denied on appeal, the Claimant will receive written notice of the denial. The notice will include:

(A) the specific reason or reasons for the denial;

(B) specific references to the pertinent Plan provisions on which the denial is based;

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

(D) a statement about the Claimant's right to bring a civil action.

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# ARTICLE VII
# AMENDMENT OR TERMINATION

## 7.1 Amendment

The University reserves, without limitation, the right to amend, modify, change, or revise the Plan and/or any Component Plan in whole or in part at any time and from time to time without advance notice thereof, except that any amendment, modification or change relating to any Insurance Contract must be in accordance with the provisions of such Insurance Contract. The Plan may be amended by the Committee or its delegate.

## 7.2 Termination

(a) **Right to Terminate**: The University has established the Plan with the intention that it will be continued indefinitely, but the University has no obligation to maintain the Plan and/or any Component Plan for any given length of time, and the University reserves without limitation the right to terminate the Plan and/or any Component Plan at any time with or without reason. Such decision to terminate the Plan and/or any Component Plan must be made in writing.

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

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# ARTICLE VIII
# HIPAA PRIVACY AND SECURITY

## 8.1 General HIPAA Provision

(a) **Hybrid Entity Designation**: The Company designates the Plan as a hybrid entity in accordance with 45 CFR Section 164.105 and only those Component Plans that would be a covered health plan under 45 CFR Section 160.103 constitute the health care components of the Plan. Any Component Plan that would not be a covered health plan under 45 CFR Section 160.103 if provided through a separate plan is a non-health care component of a hybrid entity and is not subject to 45 Code of Federal Regulations Part 160, Subparts A and E (the "Privacy Rule") or 45 Code of Federal Regulations Part 160 and 164, Subparts A and C (the "Security Rule"). Component Plans that are subject to the Privacy Rule and/or the Security Rule are referred to as the "HIPAA Plans." The University must comply with the requirements of the Privacy Rule and the Security Rule, as applicable, with respect to the HIPAA Plans. The Plan will implement appropriate safeguards to prevent the disclosure and use of PHI (as defined below) between its HIPAA Plans and other non-HIPAA components of the Plan. Furthermore, if a member of the workforce performs duties for both a HIPAA Plans and another non-HIPAA component of the Plan, such individual is prohibited from using or disclosing PHI created or received in the course of or incident to the individual's work for the HIPAA Plans in a manner contrary to HIPAA's privacy requirements.

(b) **Privacy Officer and Security Officer**: For purposes of HIPAA compliance, the privacy officer for each HIPAA Plan shall be the Chief Privacy Officer for the University of Delaware. For purposes of HIPAA compliance, the security officer for each HIPAA Plan shall be the University's appointed HIPAA Security Officer.

(c) **Organized Health Care Arrangement Designation**: The Plan Administrator intends the HIPAA Plans to form part of an Organized Health Care Arrangement along with any other benefit under a covered health plan (under 45 CFR Section 160.103) provided by the University.

## 8.2 HIPAA Privacy Provisions

(a) **Protected Health Information**: The HIPAA Plans use and disclose Protected Health Information (referred to as "PHI") as permitted or required by HIPAA. PHI generally means information that:

(1) is transmitted or maintained by the HIPAA Plans;

(2) relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual; and

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(3) identifies the individual or for which there is a reasonable basis to believe that the information could be used to identify the individual.

(b) **Disclosures of PHI to the University**: The HIPAA Plans may disclose PHI to the University only as permitted below or as otherwise required or permitted by HIPAA or other applicable law. Notwithstanding any provision of the HIPAA Plans to the contrary, in no event is the University permitted to use or further disclose PHI in a manner that is inconsistent with 45 CFR Section 164.504(f).

(1) **Participation Information**: The HIPAA Plans may disclose to the University information regarding whether an individual is participating in a HIPAA Plan.

(2) **Summary Health Information**: Except as prohibited by 45 CFR Section 164.502(a)(5)(i), the HIPAA Plans may disclose Summary Health Information to the University if the University requests the Summary Health Information for the purpose of modifying, amending or terminating a HIPAA Plan. "Summary Health Information" means information, which may be individually identifiable health information, and:

(A) summarizes the claims history, claims expenses or types of claims experienced by individuals for whom the University has provided health benefits under a HIPAA Plan; and

(B) from which the information described at 45 CFR Section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR Section 164.514(b)(2)(i)(B) need only be aggregated to the level of a 5-digit zip code.

(3) **Plan Administration Functions**: Subject to the conditions of disclosure and written certification requirements described below, the HIPAA Plans may disclose PHI to the University to allow the University to perform plan administration functions on behalf of the HIPAA Plans. The University may access and use such PHI for plan administration functions that include claims processing, quality assurance, auditing, monitoring, and other activities that would constitute "payment" and "health care operations" as those terms are defined under HIPAA. Plan administration functions do not include any functions performed by the University in connection with any other benefit or employee benefit plan of the University or any employment-related functions performed by the University.

(c) **Conditions of Disclosure for Plan Administration Functions**: With respect to PHI disclosed to the University by the HIPAA Plans (other than participation information and Summary Health Information which may be used and disclosed as described in Subsection (b) of this Section), the University agrees to the conditions described in this Subsection.

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(1) The University may not use or further disclose PHI other than as permitted or required by the HIPAA Plans or as required by law.

(2) The University must ensure that any agent to whom it provides PHI received from the HIPAA Plans agrees to the same restrictions and conditions that apply to the University with respect to such PHI.

(3) The University may not use or disclose PHI for employment-related actions and decisions or in connection with any other benefits or employee benefit plan of the University, except to the extent a use or disclosure may otherwise be permitted by HIPAA or pursuant to an authorization that complies with 45 CFR Section 164.508.

(4) If the University becomes aware of any use or disclosure of PHI by the University that is inconsistent with the uses or disclosures permitted in this Section, the University must report such use or disclosure of PHI to the HIPAA Plans.

(5) The University must make PHI available to comply with an individual's right to access the individual's PHI in accordance with 45 CFR Section 164.524.

(6) The University must make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526.

(7) The University must make available the information required to provide an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

(8) The University must make its internal practices, books and records relating to the use and disclosure of PHI received from the HIPAA Plans available to the Secretary of the Department of Health and Human Services for purposes of determining the HIPAA Plans' compliance with 45 CFR Part 164, Subpart E.

(9) When PHI that the University received from the HIPAA Plans is no longer needed for the purpose for which the disclosure was made, the University must, if feasible, return or destroy all such PHI that the University still maintains in any form and retain no copies of such information. If such return or destruction is not feasible, the University must limit further uses and disclosures to those purposes that make the return or destruction of PHI infeasible.

(10) The University must ensure adequate separation between the University and the HIPAA Plans as required by 45 CFR Section 164.504(f)(2)(iii).

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(d) **Adequate Separation Between HIPAA Plans and University**: The University ensures adequate separation between the HIPAA Plans and the University as required by 45 CFR Section 164.504(f)(2)(iii) as described in this Subsection.

(1) The University causes the HIPAA Plans to adopt policies and procedures regarding permissible disclosures of PHI to the University for plan administration purposes or other lawful purposes; and

(2) The University may allow only designated University to be given access to PHI. Such Employees may have access to and use PHI only to the extent necessary to conduct the plan administration functions that the University performs for the HIPAA Plans. Any such Employee who does not comply with this Section is subject to disciplinary action by the University based on the severity of the violation and in accordance with the University's employee disciplinary policies. If the Employee's noncompliance results in an unauthorized use or disclosure of PHI, the University must report the unauthorized use or disclosure to the HIPAA Plans. The University also must, to the extent practicable, take steps to mitigate any harmful effect known to the University that arises from such Employee's noncompliance.

(e) **Certification of the University**: The HIPAA Plans may disclose PHI to the University only upon the receipt of a certification by the University that the applicable HIPAA Plan has been amended to incorporate the provisions of 45 CFR Section 164.504(f)(2)(ii), and that the University agrees to the conditions of disclosure set forth in Subsection (c) of this Section.

(f) **Privacy Officer**: The Privacy Officer, or the Privacy Officer's designee, has the authority to and is responsible for:

(1) accepting and verifying the accuracy and completeness of any certification provided by the University under this Article;

(2) transmitting the certification to any third parties as may be necessary to permit them to disclose PHI to the University;

(3) establishing and implementing policies and procedures with respect to PHI that are designed to ensure compliance by the HIPAA Plans with the Privacy Rule;

(4) establishing and overseeing proper training of University personnel who have access to PHI; and

(5) any other duty or responsibility that the Privacy Officer, in the Privacy Officer's sole capacity, deems necessary or appropriate to comply with the Privacy Rule.

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### 8.3 HIPAA Security Provisions

(a) **Electronic PHI**: Electronic PHI generally means PHI that is:

(1) maintained in electronic storage media on which data is or may be recorded electronically, including, for example, devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk or digital memory card; or

(2) transmitted by transmission media including the Internet, extranet or intranet, leased lines, dial up lines, private networks and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile and of voice via telephone, are not considered to be transmissions via electronic media if the PHI being exchanged did not exist in electronic form immediately before the transmission.

(b) **Conditions on Disclosure of Electronic PHI to University**: With respect to Electronic PHI disclosed to the University by the HIPAA Plans (other than participation information and Summary Health Information as described in Section 8.2), the University agrees to the conditions described in this Subsection.

(1) The University must implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the HIPAA Plans.

(2) The University must ensure that the adequate separation between the HIPAA Plans and the University as described in Section 8.2(d) is supported by reasonable and appropriate administrative, physical and technical safeguards.

(3) The University must ensure that any agent to whom it provides Electronic PHI agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the Electronic PHI.

(4) The University must report to the HIPAA Plans any Security Incident of which it becomes aware. A Security Incident is the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system (an interconnected set of information resources under the same direct management control that shares common functionality that typically includes hardware, software, information, data, applications, communications and people).

(c) **Security Officer**: The Security Officer may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third party experts as the Security Officer deems necessary or advisable. In addition, and

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notwithstanding any provision of the HIPAA Plans to the contrary, the Security Officer, or the Security Officer's designee, has the authority to and is responsible for:

(1) accepting and verifying the accuracy and completeness of any certification provided by the University under this Article;

(2) transmitting the certification to any third parties as may be necessary to permit them to disclose Electronic PHI to the University;

(3) establishing and implementing policies and procedures with respect to Electronic PHI that are designed to ensure compliance by the HIPAA Plans with the Security Rule;

(4) establishing and overseeing proper training of University personnel who have access to Electronic PHI; and

(5) any other duty or responsibility that the Security Official, in the Security Official's sole capacity, deems necessary or appropriate to comply with the Security Rule.

**8.4 Interpretation and Limited Applicability**

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

**8.5 Services Performed for the University**

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

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# ARTICLE IX
# MISCELLANEOUS

## 9.1 Limitation of Rights

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

## 9.2 No Vested Rights

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

## 9.3 Right of Recovery

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

## 9.4 Subrogation and Reimbursement

Except as otherwise provided in a Component Plan, the Plan does not provide primary coverage for expenses associated with an injury or illness caused or worsened by the action of any third party which gives rise to a claim against that party, nor does it provide primary coverage for such expenses to the extent that there is other applicable coverage from a source other than the Plan (including, but not limited to, medical benefits under an automobile insurance policy). In the event that a Covered Person sustains an injury or illness as a result of an action of a third party, and the Plan pays for costs associated with such injury or illness, the Plan has the rights of subrogation and reimbursement described in this Section.

(a) **Subrogation Rights**: The Plan has the right to be subrogated to the Covered Person's rights against any third parties which arise from such injury or illness.

(b) **Reimbursement Rights**: The Plan has the right to be fully reimbursed (to the extent of benefits paid) by the Covered Person if such Covered Person obtains any financial recovery from any source, including such Covered Person's own insurance carrier or another welfare benefit plan (such as a disability plan, if any) sponsored by the University, whether by judgment, settlement, award,

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government or worker's compensation benefits, or otherwise, on account of such injury or illness, and the Plan has a lien on any such recovery. Also, by accepting benefits under the Plan in connection with such an injury or illness, the Covered Person assigns any recovery to the Plan and authorizes such Covered Person's attorney, personal representative or insurance company to reimburse the Plan. The Plan is entitled to full reimbursement:

(1) before the Covered Person is entitled to retain any part of such financial recovery, regardless of the stated reason for the financial recovery or whether the Covered Person has other costs or suffered other injuries not paid for or compensated by the Plan (notwithstanding any "Make Whole Doctrine");

(2) without regard to any claim of fault on the part of the Covered Person, whether under comparative negligence or otherwise;

(3) without reduction for attorneys' fees and other costs incurred by the Participant or Dependent in making a recovery without the prior express written consent of the Plan (notwithstanding any "Fund Doctrine," "Common Fund Doctrine," or "Attorneys' Fund Doctrine"); and

(4) notwithstanding that the recovery to which the Plan is subrogated is paid to a decedent, a minor, a decedent's estate, or an incompetent or disabled person.

(c) **Requirements for Covered Persons to Receive Benefits**: Notwithstanding any other provision of the Plan to the contrary, the payment of benefits under the Plan on account of an injury or illness as a result of an action of a third party is contingent on the Covered Person:

(1) informing the Plan Administrator of the action to be taken by the Covered Person;

(2) agreeing (in such form and to such documents as the Plan may require) to the Plan being reimbursed from any recovery from a third party and subrogated to any right of recovery the Covered Person has against a third party;

(3) refraining from action which would prejudice the Plan's subrogation rights (including, but not limited to, making a settlement which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan); and

(4) cooperating in doing what is reasonably necessary to assist the Plan in any recovery.

If the Covered Person should fail or refuse to comply with this Section, the Covered Person is not entitled to benefits under the Plan and must reimburse the Plan for any and

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all costs and expenses, including attorneys' fees, incurred by the Plan in enforcing its rights hereunder. The Plan may determine not to exercise all of the reimbursement and/or subrogation rights described in this Section in certain types of cases, with respect to certain covered groups, or with respect to certain geographic areas, without waiving its right to enforce its rights in the future as to other groups or in other geographic areas.

**9.5 Incorrect Information, Fraud, Concealment, or Error**

(a) **Right to Recover Payments**: Notwithstanding anything in the Plan to the contrary, the Plan Administrator shall be entitled to recover, in any manner the Plan Administrator in its sole discretion deems necessary or appropriate for such recovery, from a Participant, Dependent, Beneficiary or other individual any or all of any benefits paid or the amount of any liability incurred and any and all expenses incidental to or necessary for such recovery if, because of a human or systems error, or because of the provision of incorrect information or the failure to provide correct information, fraud, misrepresentation, or concealment of any relevant fact (determined in the sole discretion of the Plan Administrator) by the Participant, Dependent, Beneficiary, or other individual, the Plan:

(1) enrolls any individual in a Component Plan, provides COBRA Continuation Coverage to any individual, or pays a benefit claim under the Plan or a Component Plan;

(2) incurs a liability for failure to so enroll, provide COBRA Continuation Coverage, or pay a benefit claim;

(3) incurs a liability for terminating enrollment or COBRA Continuation Coverage; or

(4) makes any payment, overpayment or erroneous payment to any individual or entity.

(b) **Right to Terminate Participation or Take Other Appropriate Action**: Notwithstanding anything in the Plan to the contrary, subject to Section 2.4(b), the Plan Administrator will be entitled to terminate, suspend or otherwise alter the participation of any Participant, Dependent or other individual in the Plan and/or any applicable Component Plan, to the extent permitted by applicable law, and to take other appropriate action as determined in its sole discretion, if any of the following events occur:

(1) the Participant, Dependent or other individual omits, misrepresents, or provides materially false information to the Plan in connection with enrollment in or ongoing participation in the Plan or a Component Plan;

(2) the Participant, Dependent or other individual permits an individual who is not covered under a Component Plan to use a Component Plan's identification card or to falsely obtain benefits under the Plan or a Component Plan; or

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(3) the Participant, Dependent or other individual obtains or attempts to obtain benefits under the Plan or a Component Plan by means of false, misleading or fraudulent information, acts or omissions.

## 9.6 Nonassignment of Rights

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

## 9.7 No Guarantee of Tax Consequences

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

## 9.8 Withholding Taxes

To the extent that the University is required to withhold federal, state, local or foreign taxes in connection with any payment made to a Participant under a Component Plan, the University may withhold the amount so determined from the payment, or the Participant may pay the amount so determined in any other manner permitted by the Plan Administrator.

## 9.9 Indemnification of University by Participants

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

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### 9.10 Information to be Furnished

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

### 9.11 Notices and Elections

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

### 9.12 Incapacity to Receive Payment

If the Plan Administrator deems any person incapable of receiving benefit payments by reason of minority, illness, infirmity or other incapacity, it may direct payment directly for the benefit of such person, or to any person selected by the Plan Administrator to disburse it. Such payment, to the extent thereof, shall discharge all liability for such payment under the Plan. Any payment made in accordance with this section shall fully release the Plan of its liabilities with respect to the Participant or Covered Person.

### 9.13 Failure to Cash Check

With respect to any Self-Funded Component Plan, if payment for benefits is made to a Claimant in the form of a check, and such check is not cashed within one year from its date of issuance, then such payment reverts to the Component Plan's trust or, if none, to the University.

### 9.14 Payment of Expenses

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

### 9.15 Qualified Medical Child Support Orders

Medical benefits under the Plan must be administered in accordance with the provisions of any qualified medical child support order to which the Plan is subject.

### 9.16 Compliance with Federal and State Mandates

It is intended that the Plan meet all applicable requirements of the Code, PPACA and all other applicable federal and state laws and of all regulations issued thereunder. The Plan must be construed, operated, and administered accordingly. In the event of any conflict

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between any part, clause, or provision of the Plan and the Code, PPACA and/or any other applicable federal or state law, the provisions of the Code, PPACA and other applicable federal or state laws are deemed controlling, and any conflicting part, clause, or provision of the Plan is deemed superseded to the extent of the conflict.

### 9.17 Governing Law and Waiver of Jury Trial

To the extent not preempted by any federal law, the Plan is governed by and construed, enforced and administered according to the laws of the State of Delaware, other than its rules on conflict of laws. Any dispute concerning the Plan, including eligibility for and the amount (if any) of benefits shall be subject to the exclusive jurisdiction of the federal and state courts located in Delaware. Any controversy which may arise under the Plan is likely to involve complicated and difficult issues, and therefore, to the fullest extent permitted by applicable law, by participating herein, each Participant waives any right to a trial by jury in any action, proceeding or counterclaim concerning any rights under the Plan, and agrees that any such action, proceedings or counterclaim will be tried before a court and not before a jury.

### 9.18 Severability

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

### 9.19 Conclusiveness of Records

The records of the University with respect to age, length of service, employment history, compensation, absences, illnesses and all other relevant matters shall be conclusive for purposes of the administration of, and the resolution of claims arising under, the Component Plans.

### 9.20 Construction

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

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IN WITNESS WHEREOF, this instrument has been executed by the University on the 26 day of August, 2026 and effective as of July 1, 2025.

THE UNIVERSITY OF DELAWARE

Signed by:
By: Melissa Bard
0692E85ACA4841E...

Name: Melissa Bard

Title: Vice President and CHRO

8/26/2026

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# UNIVERSITY OF DELAWARE GROUP HEALTH INSURANCE PLAN
# (EFFECTIVE AS OF JULY 1, 2025)
# EXHIBIT A

## COMPONENT PLANS

| Plan/Program | Funding | Insurer | Incorporated Documents | Benefit | Claims Administrator |
|---|---|---|---|---|---|
| University of Delaware Medical and Prescription Plans | Self-Insured | N/A | Highmark Commercial Plan Document, Group No.10636049, 10636052, 10636050, 10630653, 10636051, 10636054, 10636057, 10636058<br>Highmark Medicare, Group No. 10636055, 10636056<br>Aetna Health Maintenance Organization (HMO), and Aetna Preferred Provider Organization (CDHP) Contract No, MSA-0247153<br><br>CVS Executive Template<br><br>SilverScript Summary or Benefits | Medical<br><br>Prescription Drug | Highmark<br><br>Aetna<br><br>CVS Caremark<br><br>CVS SilverScript |
| University of Delaware Dental Plan | Fully-Insured | N/A | MetLife, Metropolitan Life Insurance Company, Group Dental Insurance Certificate, Po No, 25140-1-G | Dental | MetLife |
| University of Delaware Vision Plan | Fully-Insured | N/A | Fidelity Security Life Insurance Company, Group Vision Insurance Certificate, Pol. No, VC-108 | Vision | National Vision Administrators |

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| Plan/Program | Funding | Insurer | Incorporated Documents | Benefit | Claims Administrator |
|---|---|---|---|---|---|
| Flexible Spending Accounts under the University of Delaware Section 125 Plan | Fully-Insured | N/A | University of Delaware Section 125 Plan | Health and Dependent Care flexible spending accounts | ASIFlex |
| University of Delaware Long-Term Disability Plan | Fully-Insured | N/A | MetLife Long Term Disability Income Insurance, Group Policy No. 25140-1-G | MetLife Long Term Disability | MetLife |
| University of Delaware Basic Life Insurance Plan | Fully-Insured | N/A | MetLife Term Life and Accidental Death and Dismemberment Group Policy No. 25140-1-G | MetLife Life Insurance | MetLife |
| COBRA | Self-Insured | ASICOBRA | University of Delaware Section 125 Plan | COBRA | ASICOBRA |

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