

**WRAP-AROUND PLAN AND SUMMARY
PLAN DESCRIPTION FOR THE

WEST VIRGINIA UNIVERSITY
RESEARCH CORPORATION
EMPLOYEE BENEFITS PLAN**

Health, Vision and Rx Benefits
Dental Benefits
Basic Group Term Life
Short-Term Disability Benefits
Long-Term Disability Benefits
Life Insurance Benefits
Accidental Death & Dismemberment

Amended and Restated
November 30, 2017

TABLE OF CONTENTS

1.	General Plan Information	3
2.	Plan Benefits	4
3.	Eligibility.....	6
4.	Funding	7
5.	Plan Administration.....	10
6.	Benefit Claims Procedures	15
7.	Federal Notices and Provisions.....	17
8.	Subrogation and Reimbursement Rights	24
9.	Statement of ERISA Rights.....	28
10.	Plan Adoption.....	30

1. General Plan Information

West Virginia University Research Corporation maintains this Employee Benefits Plan for the exclusive benefit of its eligible employees and other persons made eligible by their relationship to the eligible employee. This Plan is comprised of different benefit programs that are subject to Employee Retirement Income Security Act of 1974, as amended (“ERISA”). This document together with documents incorporated by reference constitutes the written plan document required by ERISA Section 402 and the Summary Plan Description required by ERISA Section 102.

The West Virginia University Research Corporation Employee Benefits Plan is amended and restated on December 1, 2016. This Plan has been in existence since January 1, 2005. This booklet contains a summary in English of participant rights and the benefits available under the West Virginia University Research Corporation Employee Benefits Plan. If you have difficulty understanding any part of this booklet, you can contact the Benefits Coordinator for assistance.

Plan Name	The West Virginia University Corporation Employee Benefits Plan
Plan Sponsor	West Virginia University Corporation One Waterfront Place P.O. Box 6221 Morgantown, WV 26506 304.293.8704
Plan Sponsor EIN Number	55-0665758
Plan Administrator	West Virginia University Corporation One Waterfront Place P.O. Box 6221 Morgantown, WV 26506 304.293.8704
Employee Benefit Contact (Plan Sponsor/Plan Administrator)	Benefit Coordinator 304.293.4616
Agent for Service of Process (service may also be made on the Plan Administrator)	Director West Virginia University Corporation One Waterfront Place P.O. Box 6221 Morgantown, WV 26506 304.293.8704
Named Fiduciary	West Virginia University Corporation One Waterfront Place P.O. Box 6221 Morgantown, WV 26506 304.293.8704
Type of Plan	The West Virginia University Corporation Employee Benefits Plan is an employee welfare benefit plan within the meaning of ERISA, and provides various benefits as set forth below under the heading Plan Benefits.

If the information appearing above contradicts any term presented in the incorporated Benefit Plan Descriptions, the information **above** will control. For example, if a Benefit Plan Description has a different Plan Number the Plan Number above controls.

2. **Plan Benefits**

- **Employer Sponsored Benefit Plan**

This Employee Benefits Plan includes the component Benefit Plan(s) identified below. Each Benefit Plan is described in full within the documents that are incorporated by reference and referred to as Benefit Plan Descriptions. This Plan is intended to comply with any applicable Federal and State mandates, which are explained in the Benefit Plan Descriptions or materials provided by the Employer.

- **Benefit Plan Table**

Type of Benefit	Insurance Carrier, Third-Party Administrator, or Service Provider	Funding Source	Insurance Policy Contract Year
Health and Rx	Highmark West Virginia	Fully- Insured	12/1 – 11/30
Dental	Lincoln Financial Group	Fully- Insured	12/1 – 11/30
Basic Group Term Life	Lincoln Financial Group	Fully- Insured	12/1 – 11/30
Accidental Death & Dismemberment (AD & D)	Lincoln Financial Group	Fully- Insured	12/1 – 11/30
Short-Term Disability	Lincoln Financial Group	Fully- Insured	12/1 – 11/30
Long-Term Disability	Lincoln Financial Group	Fully- Insured	12/1 – 11/30
Vision	Lincoln Financial Group	Fully- Insured	12/1 – 11/30

- **Benefit Plan Description**

The Benefit Plan Descriptions expressly incorporated by reference and listed above include the following items that are applicable to the type of coverage provided:

1. Complete detailed schedules of benefits, and all exclusions and limitations on benefits including subrogation rights and instances where benefits will be coordinated with other sources of payment;
2. Provisions governing the use of network providers, the composition of the provider network and whether, and under what circumstances, coverage is provided for out-of-network services;

3. The procedures governing claims for benefits including procedures for filing claim forms, providing notifications of benefit determinations, and reviewing denied claims in the case of any applicable time limits, and remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 503 of Title I of the Act). Additional detail required by law for specific claims and appeals will be furnished as separate documents without charge;
4. Cost-sharing provisions including any deductibles, coinsurance and copayment amounts for which the participant or beneficiary will be responsible;
5. Any annual or lifetime caps and all other limits on benefits;
6. The extent to which preventive services are covered;
7. Whether, and under what circumstances, existing and new drugs are covered;
8. Whether, and under what circumstances, coverage is provided for medical tests, devices and procedures;
9. Any condition or limits on the selection of primary care providers or providers of specialty medical care;
10. Any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service under a Benefit Plan;
11. A general description of the provider networks applicable to each Benefit Plan. A complete listing of providers in a network will be furnished to participants and beneficiaries as a separate document at no charge;
12. Any circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture, suspension, offset, reduction, or recovery of any benefits; and,
13. Whether and to what extent benefits under the Benefit Plan are guaranteed under a contract or policy of insurance issued by the Insurance Company, and the nature of any administrative services (e.g., payment of claims) provided by the Insurance Company or Third Party Administrator.

3. **Eligibility**

- **Eligibility for Sponsored Group Plan**

A Participant's rights to enroll in and maintain coverage under the Benefit Plans are described in detail in the Benefit Plan Descriptions listed above or enrollment materials provided by the Employer. The Benefit Plan Descriptions and the enrollment materials are expressly incorporated by reference:

1. Under what circumstances a spouse, dependents and other persons may be enrolled including any proof of a relationship needed to meet the eligibility requirements (note that group health plans are required to cover dependent children placed with a participant for adoption under the same terms and conditions as apply in the case of dependent children who are natural children);
2. The existence of any waiting periods and how they are applied;
3. When enrollment is allowed and a description of the enrollment procedures;
4. When coverage will be effective and when it will end including the events that can occur that will terminate coverage; and,
5. Details regarding when special enrollment rights allowing individuals who previously declined health coverage for themselves and their dependents have an opportunity to enroll (regardless of any open enrollment period). The Special Enrollment Notice, a copy of which was previously furnished to each participant, also contains important information about the potential special enrollment rights including a thirty (30) day time limit for requesting the enrollment. You can contact your Benefits Coordinator to receive an additional copy of that notice.
6. Details regarding when special enrollment rights for an employee who is eligible, but not enrolled for coverage (or a dependent of the employee if the dependent is eligible, but not enrolled) when either:
 - a. The employee or dependent were covered under a Medicaid plan or under a State Child Health Plan (SOUP) and that coverage is terminated as a result of loss of eligibility; or,
 - b. The employee or dependent becomes eligible for premium assistance from Medicaid or SCHIP (including assistance under any waiver or demonstration project conducted under or in relation to Medicaid or SCHIP).

The employee or dependent must request coverage under the group health plan not later than sixty (60) days after the date the employee or dependent is terminated from the Medicaid or SCHIP Plan or determined to be eligible for such assistance.

4. **Funding**

- **Explanation of Terms in Benefit Plan Table**

This Plan makes available the Benefit Plans identified under Section 2. Plan Benefits, details listed in the Benefit Plan Table, and described in the Benefit Plan Descriptions are incorporated by reference. The funding for each Benefit Plan is identified on the Benefit Plan Table and described below.

If the Benefit Plan is “Fully Insured.” Benefits are provided under an insurance contract entered into between West Virginia University Research Corporation and the Insurance Company identified on the Benefit Plan Table. Premiums must be paid to the Insurance Company to maintain the Benefit Plan. The premium is paid in part or whole from the general assets of West Virginia University Research Corporation.

If the Benefit Plan is “Self-Funded.” Benefits are paid from the general assets of West Virginia University Research Corporation. Claims processing and other delegated functions for the Benefit Plan are administered by the Third Party Administrator identified on the Benefit Plan Table.

If West Virginia University Research Corporation purchased an insurance policy that provides benefits to West Virginia University Research Corporation in the event of excess claims, commonly referred to as Stop Loss Insurance, contributions due from a participant for coverage under the Benefit Plan will not be used to pay the premium for the Stop Loss Insurance. The Stop Loss Insurance premium will be paid from the general assets of West Virginia University Research Corporation.

If the Benefit Plan is “Partially Insured” A portion of the benefits are provided as an insurance contract entered into between West Virginia University Research Corporation and the Insurance Company identified on the Benefit Plan Table. The remaining benefits are paid from the general assets of West Virginia University Research Corporation.

If the Benefit Plan includes “Employee Salary Reduction.” These tax advantage Plans are funded in part or in whole by an Employees’ salary reduction. The Benefit Plan Description includes a list of “change in status” events that limit the instances where an Employee can change pretax elections during the Plan Year. A Health Flexible Spending Account allows Employees to make elections for pre-tax reimbursement of medical expenses, including most services allowed under Section 213(d) of the Internal Revenue Code. A Health Flexible Spending Account is a health and welfare plan subject to ERISA and Section 105 of the Internal Revenue Code. The Health Flexible Spending Account has limited COBRA continuation rights, COBRA is only offered if the cost to continue to the end of the Plan Year is greater than the available benefit and continuation is only available to the end of the current Plan Year. Claims processing and other delegated functions for the Benefit Plan are administered by the Service Provider identified on the Benefit Plan Table.

Plan Sponsor - Employee Contributions/Spending Credits. If employee contributions are required for any Benefit Plan, then West Virginia University Research Corporation will determine and communicate the employee's required contribution and the method of payment at open enrollment and as needed throughout the Plan Year. West Virginia University Research Corporation can change that determination at any time. These communications are expressly incorporated by reference. The Plan Sponsor may use Plan assets to pay reasonable administrative expenses of the Plan as needed.

West Virginia University Research Corporation may provide additional contributions in the way of cash or spending credits that can be used for any Benefit Plan, or used in a limited manner as defined by the Plan Sponsor. The Plan Sponsor may make defined contributions to specific Benefit Plans and require that you pay a portion or all of the cost for coverage under any Benefit Plan. The enrollment materials used each Plan Year include the amount of any Plan Sponsor contributions, the rules defining how the Plan Sponsor contributions can be used by Participants, and include all limitations on the use of Plan Sponsor contributions. The enrollment materials are expressly incorporated by reference.

If West Virginia University Research Corporation is or becomes subject to the FMLA, then Plan Sponsor contributions will continue to be provided while on an approved FMLA leave to the same extent provided to an Employee actively at work.

5. Plan Administration

- **Plan Administrator**

The Plan Administrator is responsible for the administration of this Plan. Should you need to see any records or have any questions regarding any Benefit Plan, contact the Plan Administrator. The Plan Administrator has final discretionary authority to interpret the Plan and make factual determinations as to whether any individual is eligible for coverage and entitled to receive any benefits under the Plan. The Benefit Coordinator has been appointed to assist you in answering questions and providing information to you regarding your benefits and elections. The Plan Administrator may delegate any of the responsibilities to the Insurance Company or Third Party Administrator identified in the Benefit Plan Table. The Plan Administrator is not responsible for any Benefit Plan identified as "Individual" on the Benefits Plan Table.

The Plan Administrator will have the following rights, duties and powers to:

1. Interpret the terms of any Benefit Plan, to determine the amount, manner and time for payment of any benefits, and to construe or remedy any ambiguities, inconsistencies or omissions, and correct any administrative errors or omissions;
2. Adopt and apply any rules or procedures to insure the orderly and efficient administration of any Benefit Plan;
3. Determine the rights of any participant, spouse, dependent or beneficiary to benefits under any Benefit Plan;
4. Develop appellate and review procedures for any participant, spouse, dependent or beneficiary to benefits under any Benefit Plan;
5. Provide the Plan Sponsor with such tax or other information it may require in connection with any Benefit Plan;
6. Employ any agents, attorneys, accountants or other parties (who may also be employed by the Plan Sponsor) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of any Benefit Plan, provided that such allocation or delegation and the acceptance thereof is in writing; and
7. Report to the Plan Sponsor, or any party designated by the Plan Sponsor, after the end of each Plan year regarding the administration of the Plan, and to report any significant problems as to the administration of any Benefit Plan and to make recommendations for modifications as to procedures and benefits, or any other change which might insure the efficient administration of any Benefit Plan.

Subject to applicable State or Federal law, any interpretation of any provision of this Plan made in good faith by the Plan Administrator and any determination by the Plan Administrator as to any Participant's rights or benefits under this Plan is final, shall be

binding upon the parties and shall be upheld on review, unless it is shown that such interpretation or determination was an abuse of discretion (*i.e.*, arbitrary and capricious).

- **The Federal Privacy Rule (HIPAA)**

As required by law, this plan complies with the applicable provisions the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). HIPAA provisions apply to group health plans only and not to all benefit plans offered under this plan.

Continuity of Coverage. HIPAA requires that your group health plan reduce or eliminate the exclusionary period of coverage for preexisting conditions under your group health plans (not long term disability plans), if you have creditable coverage from another plan. Typically you should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or if you request it up to 24 months after losing coverage. Typically, without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion of 12 months (18 months for late enrollees) after your enrollment date in your coverage. You must request enrollment in writing within 30 days of the marriage, birth, adoption, or placement for adoption. Coverage will become effective retroactive to the date of marriage, birth, adoption, or placement for adoption.

Privacy Requirements. The Privacy Requirements apply only to those components of the Plan that constitute a Health Plan subject to the HIPAA Privacy Rule. This Plan is subject to HIPAA”, and its implementing regulations, (these regulations are referred to as the “HIPAA Privacy Rule,” as amended). HIPAA places restrictions on the Plan Sponsor’s access to use and disclosure of Protected Health Information (PHI). If HIPAA applies to a specific component of the this Plan, the Plan will protect the confidentiality and privacy of individually identifiable health information, and the Plan and those administering it will use and disclose health information only as allowed by Federal law and only in accordance with a HIPAA Privacy Policy established by the Administrator, the terms of which are incorporated herein by reference. You may obtain a copy of the HIPAA Privacy Policy from your Human Resources Representative.

Hybrid Entity Election. The document is a legal wrap plan document that incorporates by reference various separate benefit programs, some of which are group health plans and others are non-group health plans. As a result, HIPAA may treat this wrap plan document as offering a healthcare component and a non-healthcare component and consequently, it is considered a “hybrid entity” as defined under 45 C.F.R. §164.103. In this case, the healthcare component of this document consists of the group health plans (including any Medical, Dental, Vision, and/or Health Care Flexible Spending Account benefits). The non-healthcare component of the Plan consists of all other benefits under the Plan. The Plan and Employer intend to comply with HIPAA with respect to only the healthcare component of the Plan and to ensure adequate separation between the healthcare component and the non-healthcare component and to clarify that such healthcare component and non-healthcare component are separate and distinct plans. In this regard

and to the extent required by HIPAA, the Plan and the Employer will ensure compliance with the safeguard requirements relating to hybrid entities as set forth in 45 C.F.R. §164.105(a) and in the Plan's HIPAA Privacy Policies and Procedures.

- **The Federal Security Rule**

This Term is intended to bring the Plan into compliance with the "HIPAA Security Rule" as published on February 20, 2003 by the United States Department of Health and Human Services (HHS), and amended, including the final Security Standards HIPAA and the HITECH Act (Health Information Technology for Economic and Clinical Health Act) of 2009.

The Electronic Media contemplated by the HIPAA Security Rule includes:

1. Electronic storage media, including memory 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. Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), 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, because the information being exchanged did not exist in electronic form before the transmission.

In order to send and receive PHI (as defined in the Plan Document) necessary for Plan administration by Electronic Media, the Plan Sponsor will:

1. Implement reasonable and appropriate safeguards for electronic PHI created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the group health plan;
2. Ensure that electronic "firewalls" are in place to secure the electronic PHI;
3. Ensure that all agents and subcontractors with access to electronic PHI comply with the security requirements; and
4. Report to the group health plan any security incident of which it becomes aware.

- **Right to Truthful and Complete Information**

Benefits are conditioned on the Participants cooperation in providing such information and documentation necessary to verify eligibility for coverage and substantiate claims submitted. This may include Participant medical records, a physical examination during the pendency of any claim to the extent allowed by law, and an autopsy in the case of death except where expressly forbidden by law.

If a Participant intentionally makes a false statement or submits false documents in support of coverage or in support of a claim for benefits, or a Participant intentionally fails to send correct information when the participant knows or should have known the information submitted was incorrect, the Plan Administrator may, without the consent of any person, and to the fullest extent permitted by law, terminate the person's Plan coverage and may refuse to honor any claim for benefits under the Plan including claims for beneficiaries participating in the Plan due to his/her relationship to the person submitting the falsified information. Such person shall be responsible, to the fullest extent permitted by applicable law, to provide restitution, including monetary repayment to the Plan, with respect to any overpayment or ineligible payment of benefits.

- **Termination and Amendment of the Plan**

The Plan Sponsor expects to maintain the Plan indefinitely as an employee welfare benefit plan. However, the Plan Sponsor has the right, in its sole discretion, to terminate the Plan or to modify or amend any provision of the Plan at any time. In the event of the dissolution, merger, consolidation or reorganization of the Plan Sponsor, the Plan automatically will terminate unless it is continued by the successor to the Plan Sponsor.

Participants in the Plan have no Plan benefits after a Plan termination or a partial Plan termination affecting them, except with respect to covered events giving rise to benefits and occurring prior to the date of Plan termination or partial termination and except as otherwise expressly provided, in writing, by the Plan Sponsor.

- **No Continued Employment**

No provisions of the Plan or this Summary shall give any employee any rights of continued employment with the Plan Sponsor or shall in any way prohibit changes in the terms of employment of any Employee covered by the Plan.

- **Non-Assignment of Benefits**

Except as may be required pursuant to a "Qualified Domestic Relations Order" or a "Qualified Medical Child Support Order" (which provide for Plan coverage for an alternate recipient), other applicable law, or electronic payment made directly to a health care provider, no Participant or beneficiary may transfer, assign or pledge any Plan benefits.

- **Excess Payments**

Upon any benefit payment made in error under the Plan, the Plan Sponsor will inform you that you are required to repay the amount that has been paid under this Plan in error. This includes, but is not limited to, amounts over your annual election, amounts for services that are determined not to be qualified expenses, or when you do not provide adequate documentation to substantiate a paid claim upon request. The Plan Sponsor may take reasonable steps to the extent permissible by law to recoup such an amount including withholding the amount from

future salary or wages, and reducing the amount of future benefit reimbursements by the amount paid in error.

- **Nondiscrimination**

The Plan is not intended to discriminate in favor of highly compensated individuals as to eligibility to participate, contributions and benefits in accordance with applicable provisions of ERISA and the Internal Revenue Code. The Plan Administrator may take action, such as excluding certain highly compensated employees from participation in the Plan in the Plan Administrator's judgment, to the extent such actions serve to assure that the Plan does not violate applicable nondiscrimination rules.

If your employer has multiple "Medical, Surgical, Hospital Care" Benefit Plans as identified on the Plan Benefits Table in Section 2, where necessary in order to satisfy plan nondiscrimination requirements, these Benefit Plans may be disaggregated for testing purposes in order to insure each Benefit Plan satisfies the nondiscrimination requirements provided under State and Federal laws and regulations.

- **Misstatements**

Any misstatement or other mistake of fact will be corrected as soon as reasonably possible upon notification to the Plan Administrator and any adjustment or correction attributable to such misstatement or mistake of fact will be made by the Plan Administrator as he/she considers equitable and practicable.

- **No Guarantee of Tax Consequences**

The Plan Sponsor does not guarantee the tax status of employee contributions to any Benefit Plan, nor the tax free status of any benefit paid by or from any Benefit Plan.

6. **Benefit Claims Procedures**

How to File a Claim. Certain services must be pre-authorized as defined by the plan and outlined in the Benefit Plan Description for each separate benefit. Claims for benefits, unless otherwise stated in the Benefit Plan Description, must be made in writing by you. A claim form can be obtained from the appropriate Benefit Plan or Benefit Coordinator. You must furnish the appropriate Benefit Plan with information regarding the loss for which benefits are being claimed within the guidelines established in the applicable Benefit Plan Description. Guidelines for when exceptions can be made to the non-timely filing rules or specific claims filing information may be found within the Benefit Plan Description for each separate benefit. Claim forms contain complete instructions for their completion and where and how to file a claim. Read the claim form carefully and make sure you answer all questions and include any required information. You will be notified in writing of any benefits denied in whole or in part or if any additional information is required.

Determination of Health, Disability or Non-Health Claims. The determination of whether a claim falls under the procedures for health claims or under the procedures for disability and other non-health claims is based on the nature of the specific claim or benefit, not the characterization of the plan under which the claim is made or the benefit is offered.

How to Appeal a Claim For Health Claims Only. For a detailed description of the required procedures for filing claims and of the appeals procedures for any denied claims, please refer to the Benefit Plan Description for each of the separate benefit plans.

The following is a general overview of the basic requirements for appealing claims, but this summary does not cover incomplete claim filings, procedures for extension with notice, and certain other procedures. These are general standards. The actual procedures used by any Benefit Plan will be as set forth in the Benefit Plan Description provided by such entity. Any conflict between the Benefit Plan Description and the claims procedures in effect for such Benefit Plan shall control over anything provided herein.

In general, how you file a claim for benefits depends on the type of claim it is and the requirements of the Benefit Plan which handles the benefits in which you seek coverage for. There are several categories of benefits:

Concurrent Care Claim – A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously approved benefit claim. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought.

Pre-Service Care Claim – A pre-service claim is a claim for a benefit under the Plan with respect to which the terms of the Plan require approval (usually referred to as precertification) of the benefit in advance of obtaining medical care.

Post-Service Care Claim – A post-service claim is a claim for a benefit under the Plan that is not a pre-service claim.

Urgent Care Claim – An urgent care claim is any claim for medical care or treatment with respect to which, in the opinion of the treating physician, lack of immediate processing of the claim could seriously jeopardize the life or health of you or your insured dependent or subject you or your dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies.

You may file any claim for benefits, including ones for concurrent care, pre-service care, or post-service care, yourself, by your authorized representative, or by your health care provider. Any of these types of claims must be filed using a written form supplied by the Claims Administrator which handles the benefits for which you seek coverage.

If your claim involves urgent care, you may initiate a claim for urgent care benefits yourself if you are able, or your treating physician may file the claim for you. The claim may be made by telephone (using the telephone number set out in the applicable Benefit Plan Description, or by U.S. Mail, by hand delivery or by facsimile (FAX). Unless permitted in the Benefit Plan Description by the Benefit Plan handling the benefit in which you seek coverage for, email shall not be considered an appropriate method for initiating a claim for any benefits. If your claim is filed by telephone, you will be responsible for completing any follow-up paperwork the Benefit Plan may require in support of your claim.

You may file any claim yourself, or you may designate another person as your “authorized representative” by notifying the Benefit Plan in writing of that person's designation. In that case, all subsequent notices and decisions concerning that claim are provided to you through your authorized representative.

The Benefit Plan provides forms for filing those claims and authorized representative designations under the Plan that must be filed in writing.

7. **Federal Notices and Other Provisions**

- **Newborn's and Mother's Health Protection Act.** Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of forty-eight (48) hours or ninety-six (96) hours, as applicable).
- **Women's Health and Cancer Rights Act (WHCRA).** If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:
 1. all stages of reconstruction of the breast on which the mastectomy was performed;
 2. surgery and reconstruction of the other breast to produce a symmetrical appearance;
 3. prostheses; and
 4. treatment of physical complications of the mastectomy, including lymphedema.

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

If you would like more information on WHCRA benefits, please contact the Plan Administrator.

- **Pre-Existing Conditions.** A pre-existing condition is an illness or injury for which you or your dependent have received any diagnosis, medical advice or treatment, or taken any prescribed drug, or where distinct symptoms were evident before your effective date of coverage under the group insurance policy.
- **Pre-Existing Condition Exclusions for Children under Age 19.** Pursuant to the Patient Protection and Affordable Care Act as applicable to the Plan, any pre-existing condition waiting period for medical benefits shall not be applicable to children under age 19. This provision shall be effective for Plan Years beginning after September 23, 2010.

New protections under the Affordable Care Act (ACA) prohibit group health plans from imposing any preexisting condition exclusion. Under this protection, a plan generally cannot limit or deny benefits relating to a health condition that was present before your enrollment date in the plan.

- **Family Medical Leave Act (FMLA).** When required by law, our Employee Benefit Plan will comply with the Family and Medical Leave Act (FMLA) requiring continuation rights for health benefits coverage assuming the Employer/Plan Sponsor meets certain criteria during the preceding calendar year. If the Employer/Plan Sponsor is subject to the law and you are covered under health benefit plans, you may be able to continue the coverage under our benefit plan for a certain period of time. You may have to pay for coverage that is continued during your FMLA leave. Contact the Plan Administrator or Benefit Coordinator for additional information.
- **Uniformed Services Employment and Reemployment Rights Act (USERRA).** If you are going into or returning from military service, you may have special rights involving health care coverage. Please see your applicable Benefit Plan Description, Plan Administrator or Benefit Coordinator.
- **Special Medicaid/CHIP Enrollment Rights.** Effective as of April 1, 2009, eligible employees are provided with an additional special mid-year enrollment opportunity in two circumstances:
 1. **Termination of Medicaid or CHIP Coverage** - The eligible employee or dependent is covered under a specified Medicaid plan or under a specified State child health plan and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan not later than 60 days after the date of termination of such coverage.
 2. **Eligibility for Employment Assistance under Medicaid or CHIP** - The eligible employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.
- **Special Enrollment for Dependent Children (age 26).** For Plan Years beginning on or after January 1, 2011, dependent children of a health benefit Participant who have not attained the age of 26 years ("Adult Children") may participate in the health benefits provided under the Plan as a dependent of the Participant, except as otherwise provided. Dependents of any Adult Child are not eligible to participate in the Plan. As used herein, the term "dependent children" shall only mean the son, daughter, stepson, stepdaughter, or a legally adopted child of the Participant.

- **Continued Coverage for Full-Time Dependent Students on Medically Necessary Leave of Absence.** Michelle's Law provides continued coverage under group health plans for dependent children who are covered under group health benefits as a full-time student but loses their student status because they take a medically necessary leave of absence from school.

As a result, if your child is no longer a full-time student, as defined in the underlying group health insurance benefit, because he or she is on a medically necessary leave of absence, your child may continue to be covered under the group health benefit for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the first day of the leave of absence, your child was (1) covered under the group health benefit; and (2) enrolled as a full-time student at a post-secondary educational institution (includes colleges and universities).

For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at the institution, that:

1. begins while the child is suffering from a serious illness or injury,
2. is medically necessary, and
3. causes the child to lose full-time student status for purposes of coverage under the underlying group health benefit.

The coverage provided to dependent children during any period of continued coverage:

1. is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the group health benefit would otherwise terminate, and
2. stays the same as if your child had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the Plan is changed during this one-year period, the group health benefit will provide the changed coverage for the dependent child for the remainder of the medically necessary leave of absence unless, as a result of the change, no group health benefit provides coverage for dependent children.

If you believe your child is eligible for this continued coverage, the child's treating physician must provide a written certification to the Plan stating that your child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

You may contact the Plan Administrator or the Benefit Coordinator for any questions on this special coverage or to obtain the appropriate certification form.

- **Genetic Information.** The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to a request for medical information. “Genetic information” as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

GINA prohibits the Employer and the Plan from:

1. Using genetic information to determine eligibility for coverage or to impose pre-existing condition exclusions;
2. Adjusting your premium and contribution amounts on basis of genetic information;
3. Requesting or requiring you or a family member to undergo a genetic testing;
4. Requesting, requiring or purchasing genetic information for underwriting purposes; or
5. Requesting, requiring or purchasing genetic information about an individual prior to or in connection with an individual’s enrollment under the plan.

GINA also makes it illegal for the Employer to discriminate against you with respect to your compensation or the terms, conditions or privileges of employment on the basis of your genetic information and from collecting such data, except as otherwise permitted by law.

- **Mental Health Parity Act.** If the medical plan provides benefits for mental health or substance abuse disorders, then generally effective January 1, 2010, the Mental Health Parity Act requires equal treatment of mental health and substance abuse benefits in parity with medical/surgical benefits.

This generally means that:

1. Financial requirements and treatment limits applicable to mental health and substance abuse are no more restrictive than those limits and requirements on medical/surgical (e.g. deductibles, copays, coinsurance, out-of-pocket, treatment limits, not just annual and lifetime dollar limits);

2. Out-of-Network Benefits provided for medical/surgical also must be available for mental health and substance abuse; and
3. Criteria for medical necessity and reason for claim denials must be made available.

The underlying benefits guide for the medical plan will provide an explanation of the covered and excluded benefits, which will comply with the Mental Health Parity Act.

Medical plans are allowed to specify inpatient day limits, and limitations on outpatient treatments. You should check your Benefit Plan Description for any limits that may apply to your coverage election.

- **Annual and Lifetime Limits.** Any annual or lifetime benefit limits previously applicable under the Plan will not be imposed for Plan years beginning on or after January 1, 2014 for “Essential Health Benefits” as defined by law.
- **Medical Loss Ratio Rebates.** In certain circumstances under the ACA, rebates may be paid to this Plan. Federal law requires that the issuer of the rebate (the insurance company) provide you a written notice of a rebate, at the time the rebate is paid to the Plan. The rebate will be prorated between the amount attributable to Plan costs paid by the employer and Plan costs paid by Participants. The participant portion of the rebate will be used for the benefit of the Plan Participants. The Employer has the sole discretion as to how the rebate will be used for the benefit of Plan participants. The employer can decide that the participant rebate will be used to lower the Plan costs for the participants for the next Plan Year, applied towards the cost of administering the Plan, paid as taxable income to the participants or in any manner that allocates the rebate to participants based on each participant’s actual contributions, or to apportion it on any other reasonable basis.
- **Return of Dividends, Premiums, or Reserves.** Because the amount of employee contributions is fixed each year and the Company makes up the difference between those contributions and the costs of the Plan, any dividends and returned premiums or reserves, credited under an insurance policy are the property of the Company. To that extent, dividends and return of premiums or reserves do not become assets of the Plan.
- **Designation of Primary Care Physician (“PCP”).** One or more of the health insurance options made available under the Plan may require the designation of a Primary Care Physician (“PCP”). You have the right to designate any PCP who participates in the network and who is available to accept you and your family members. Until you make this designation, the underlying insurance company may designate a PCP for you. For information on how to select a PCP or for a list of participating physicians, please contact the insurance company or your human resources representative.
- **Notice of HIPAA Special Enrollment Rights.** Under HIPAA, our group health plan is required to provide you information explaining our group health plan’s procedure for your special enrollment rights.

- **Special Enrollment Rights** - If you are declining enrollment in our group health plan for yourself or your dependents (including your spouse) because of other health insurance or other group health plan coverage, you may be able to enroll yourself and your dependents in our group health insurance if you or your dependents lose eligibility for that other coverage (or if the other employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the other employer stops contributing toward the other coverage).
- **Continuation Coverage (COBRA)**

Introduction

You are receiving this notice because you are or may be eligible for coverage under the Plan. Please consult the Plan Administrator or Benefit Coordinator to determine your eligibility. This notice contains important information about your right to continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which is a temporary extension of health benefits coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. COBRA will not be available to you or your beneficiaries during periods in which the Plan Administrator determines COBRA is inapplicable.

The right to COBRA health care continuation coverage was created by a federal law. COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

Other health coverage alternatives may also be available to you through the government Health Insurance Marketplace (Marketplace). In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your

spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the health care provisions of the Plan because either one of the following qualifying events happens:

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

Furthermore,

1. If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:
2. Your spouse dies;
3. Your spouse's hours of employment are reduced;
4. Your spouse's employment ends for any reason other than his or her gross misconduct;
5. Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
6. You become divorced or legally separated from your spouse.

Additionally,

1. Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:
2. The parent-employee dies;
3. The parent-employee's hours of employment are reduced;
4. The parent-employee's employment ends for any reason other than his or her gross misconduct;
5. The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
6. The parents become divorced or legally separated; or

7. The child stops being eligible for coverage under the plan as a “dependent child.”

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becomes entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event. COBRA will not be available to you or your beneficiaries during periods in which the Plan Administrator determines COBRA is inapplicable.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to: Attention: Benefits Administrator

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

Disability extension of 18-month period of continuation coverage – If you or anyone in

your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Written notice of this event should be provided to Attention: Human Resources.

Second qualifying event extension of 18-month period of continuation coverage – If your family experiences another qualifying event while receiving eighteen (18) months of COBRA continuation coverage, the spouse and dependent children in your family can get up to (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

F. Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

G. Medical Flexible Spending Accounts ("FSAs")

If a Medical Flexible Spending Account is maintained by the Employer, you may be able to make a separate COBRA election to continue the Medical FSA. Please see the specific Benefit Plan Description relating to the Medical Flexible Spending Account for more information.

H. Veterans Act

Under the Veterans Benefits Improvement Act of 2004, coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") was amended. The new rule provides that if you are called up to military active duty you will be given an opportunity to continue health coverage for yourself and your family for 24 months, instead of 18 months. This extended period applies to individuals electing coverage beginning on or after December 10, 2004. Please note that coverage under USERRA is not the same as COBRA and different rules may apply in the event of various events, such as divorce or death. However, the Plan Administrator has elected to apply the same procedures as for notification and election of COBRA coverage to the 24 month of USERRA coverage.

I. If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be

addressed to the Plan Administrator or Benefit coordinator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

- **Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to any Benefit Plan or to the Plan Administrator.

8. Subrogation and Reimbursement Rights

- **Subrogation**

The Plan retains its right to subrogation and reimbursed for all payments of benefits, if you, your dependents or any other Covered Person is paid benefits by or through the Plan due to any injury or illness which arises out of the acts or omissions of any person or entity. By accepting benefits under the Plan, each Covered Person must accept the subrogation provisions contained herein.

The term Covered Person as used hereinafter shall include the employee, participant, or any eligible dependent as defined elsewhere in the Plan, related insurance contracts and agreements.

In the event of any payment under the Plan, the Plan shall, to the extent of such payment, be subrogated to all the rights of recovery of a Covered Person which arise out of the acts or omissions of any person or entity or which arise under any no-fault coverage or any uninsured or underinsured coverage (for the purpose of this provision, collectively referred to as "Other Coverage").

The Plan is subrogated to all rights of recovery of a Covered Person regardless of whether the Covered Person obtains a full or partial recovery from such person, entity or Other Coverage.

The Plan's subrogation interest shall take priority over any and all rights of recovery held by a Covered Person against such person, entity, or Other Coverage arising out of the event which triggered the Plan's payment of Medical Benefits. The Plan's subrogation interest shall apply regardless of whether the Covered Person has been or will be made whole and regardless of whether the Covered Person has incurred fees or will be made whole and regardless of whether the Covered Person has incurred fees or costs in order to obtain a recovery from any person, entity, or Other Coverage. The "make-whole" rule **shall not apply**.

In the event the Plan has a subrogated interest or right of recovery, no Covered Person shall

release any party, person, corporation, entity, insurance company, insurance policies, or funds that may be liable or obligated to the Covered Person for the acts or omissions of any person or entity without the written approval of the Plan.

In the event a Covered Person pursues a claim against any person, entity, or Other Coverage, the Covered Person agrees to include the Plan's subrogated interest and rights of recovery in that claim, and if there is a failure to do so, the Plan shall be legally presumed to be included in such claim. In the event a Covered Person does not pursue a claim against any person, entity, or Other Coverage, the Plan shall have the right to pursue, sue, compromise, or settle any such claims in the Covered Person's name and to execute any and all documents necessary to pursue said claim in the Covered Person's name.

- **Reimbursement**

Each Covered Person hereby agrees to reimburse the Plan, for benefits paid by or through the Plan, out of any money recovered from any person, entity, or Other Coverage as the result of judgment, settlement, or otherwise, regardless of how the money is classified.

The Plan has the right to be reimbursed in an amount equal to the amount of for benefits paid by or through the Plan, regardless of whether the Covered Person obtains a full or partial recovery from such person, entity or Other Coverage. The Plan shall be reimbursed on a first priority basis, regardless of whether or not the Covered Person has been or will be made whole and regardless of whether the Covered Person has incurred fees or costs in order to obtain a recovery from any person, entity, or Other Coverage. The “make-whole” rule **shall not apply**.

In the event a Covered Person settles, recovers, or is reimbursed by any person, entity, or Other Coverage, the Covered Person shall hold any such money in trust for the benefit of the Plan. If a Covered Person fails to reimburse the Plan in accordance with this provision, the Covered Person shall be liable to the Plan for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person. Each Covered Person also agrees to execute and deliver all necessary instruments, to furnish such information and assistance, and to take any action the Plan Administrator may require to facilitate enforcement of its rights under this Plan.

The Plan will not pay or be responsible for, without the written consent of the Plan Administrator, any fees or costs associated with a Covered Person pursuing a claim against a third party or any other coverage. The Plan's subrogation interest and the Plan's reimbursement interest shall not be subject to offset for any fees or costs associated with a Covered Person pursuing a claim against a third party or any Other Coverage.

For purposes of this provision, the term “Covered Person” includes anyone acting for, or on behalf of, a Covered Person when the Covered Person is referred to as taking an action.

You must not do anything to impair or negate the Plan’s Right to Subrogation; and if any of your acts or omissions to act compromise this right to Subrogation, this Plan may seek reimbursement of all appropriate benefits paid directly to you and/or your

Dependents.

If you recover lost wages benefits from another source, e.g. from an individual who caused the injury which resulted in your receiving time loss benefits, the Plan has a right to seek repayment from you of any lost benefits which, in addition to the lost wages benefits recovered from the other source, exceed your periodic wage income prior to the disability.

9. Statement of ERISA Rights

Finally, as a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for twelve (12) months (eighteen (18) months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

This booklet contains a summary in English of your plan rights and benefits under the Benefit Plans. If you have difficulty understanding any part of this booklet, contact the Plan Administrator or the Benefit Coordinator.

10. Plan Adoption

By signing this Plan Document, the Employer identified below represents that it has formally adopted this Employee Benefits Plan.

Revised: October 3, 2017

Address Change

Revised: November 30, 2017

Vendor Change for Dental and Vision to Lincoln Financial. No plan design change.

West Virginia University Research Corporation

By: _____

Printed: _____

Title: _____

Date: _____