

Welfare Benefit Plan

Plan Document

WRAP Plan

Hampden Sydney College
Life Accident and Disability Insurance Plan

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Hampden Sydney College Life Accident and Disability Insurance Plan

PLAN DOCUMENT

DEFINITIONS

When used in the Plan with initial capital letters, the following words and phrases will have the meanings set forth below unless the context indicates that other meanings are intended.

ACA

Means the Patient Protection and Affordable Care Act of 2010 as amended from time to time.

ACCIDENTAL DEATH AND DISMEMBERMENT PLAN COMPONENT (ADD PLAN COMPONENT)

Means a Basic ADD Plan Component or a Voluntary ADD Plan Component.

ADOPTING EMPLOYER

Means any corporation, sole proprietor, or other entity named in the Adoption Agreement and any successor who by merger, consolidation, purchase, or otherwise assumes the obligations of the Plan. The Adopting Employer will be a named Fiduciary for purposes of ERISA section 402(a).

ADOPTION AGREEMENT

Means the document executed by the Adopting Employer through which it adopts the Plan and thereby agrees to be bound by all terms and conditions of the Plan.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT PLAN COMPONENT (BASIC ADD PLAN COMPONENT)

Means a Plan Component that provides a death benefit consisting of life insurance to a Beneficiary in case of the accidental death of the Participant, or a portion of the benefit for the loss of a limb or the loss of use of specific body parts by the Participant, as a result of an accident.

BASIC LIFE INSURANCE PLAN COMPONENT

Means a Plan Component that provides a death benefit to a designated Beneficiary as a result of the death of the Participant.

BASIC PLAN DOCUMENT

Means this Basic Plan Document.

BENEFICIARY

Means the individuals who are designated by the Participant or the Plan Component to receive benefits from the Plan. An Eligible Dependent is a Beneficiary of the Plan Component.

BUSINESS TRAVEL ACCIDENT PLAN COMPONENT

Means a Plan Component that provides a benefit consisting of life insurance in case of the accidental death of the Participant during business-related travel, or a portion of the benefit for the loss of a limb or the loss of use of a specific body part.

CHILD

Means an individual who is 1) the son, daughter, stepson, or stepdaughter of the Participant, or 2) an eligible foster child of the Participant pursuant to Code section 152(f)(1).

CLAIM

Means a request for benefits made by a Claimant in accordance with the Plan's procedures.

CLAIMANT

Means a Participant or Eligible Dependent who submits a Claim under a Plan Component.

COBRA

Means the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended from time to time.

CODE

Means the Internal Revenue Code of 1986 as amended from time to time.

COMPONENT DOCUMENT

Means any and all Insurance Policies and other documents, such as benefits booklets, that set forth the terms and conditions of a Plan Component. The Component Documents, including all terms and conditions of each Plan Component, are incorporated by reference in this document and constitute part of the Plan. Any amendment to a Component Document will automatically constitute an amendment to the Plan.

CONTRIBUTION

Means the amounts paid by the Employer or the Participant equal to the cost of coverage under a Plan Component.

DEPENDENT

Means the Spouse, Child, or other dependent of an Employee, as defined in the applicable Component Document.

DOL

Means the Department of Labor.

DOMESTIC PARTNER

Means an individual who is in a domestic partnership with the Participant as defined in the applicable Component Document and as determined by the Employer.

EFFECTIVE DATE

Means the date the Plan (or amendment or restatement of the Plan) becomes effective as indicated in the Adoption Agreement.

ELECTRONIC PROTECTED HEALTH INFORMATION

Means Protected Health Information that is transmitted by electronic media or maintained in electronic media and as defined pursuant to HIPAA Privacy Rule section 160.103. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disenrollment information and summary health information.

ELIGIBLE DEPENDENT

Means a Dependent that becomes covered under one or more of the Plan Components.

ELIGIBLE EMPLOYEE

Means, an Employee that satisfies the Plan's eligibility requirements under Plan Section 2.01.

EMPLOYEE

Means an individual whom the Employer classifies as a common-law employee and who is on the Employer's payroll, but does not include the following: 1) any leased employee (including but not limited to those individuals defined as leased employees in Code section 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's payroll or is determined by the IRS or others to be a common-law employee of the Employer; and 2) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer.

EMPLOYEE ASSISTANCE PROGRAM PLAN COMPONENT

Means a Plan Component that provides benefits in the form of assessments, counseling, or referral services to assist in managing personal situations.

EMPLOYER

Means the Adopting Employer and Participating Employers. A partnership is considered to be the Employer of each of the partners and a sole proprietorship is considered to be the Employer of the sole proprietor.

ENTRY DATE

Means the first day after the Eligible Employee or the Eligible Dependent has satisfied the applicable eligibility requirements of the applicable Plan Component, provided that a timely coverage election is made in accordance with the terms of the applicable Plan Component. Each Plan Component may establish separate enrollment procedures, including applicable entry dates.

ERISA

Means the Employee Retirement Income Security Act of 1974 as amended from time to time

FIDUCIARY

Means a person who exercises any discretionary authority or control with respect to management of the Plan or has any discretionary authority or responsibility regarding the administration of the Plan, as defined in ERISA section 3(21). The Employer and such other individuals either appointed by the Employer or deemed to be fiduciaries as a result of their actions shall serve as Fiduciaries under this Plan and fulfill the fiduciary responsibilities described in Part 4, Title I of ERISA including discharging their duties with respect to the Plan solely in the interest of the Participants, Eligible Dependents, and Beneficiaries with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

FMLA

Means the Family and Medical Leave Act of 1993 as amended from time to time.

HEALTH CARE PLAN COMPONENT

Means an employee welfare benefit plan that provides medical care to Employees and their Dependents either directly, through insurance or reimbursement, or otherwise and includes an Employee Assistance Program Plan Component.

HIPAA

Means the Health Insurance Portability and Accountability Act of 1996 as amended from time to time.

INDEPENDENT REVIEW ORGANIZATION (IRO)

Means an entity that conducts independent external reviews of adverse benefit determinations.

INSURANCE POLICY

Means each applicable insurance contract and health maintenance organization ("HMO") contract or other similar contract, any amendments thereto, and any successor contract.

INSURER

Means an insurance company, insurance service, or insurance organization that is licensed to engage in the business of insurance in a state, that is subject to state law regulating insurance, and that issues an Insurance Policy. The term Insurer also includes an HMO that is either a federally qualified HMO, an organization recognized as an HMO under state law, or a similar organization regulated for solvency under state law in the same manner and to the same extent as such an HMO and that issues an Insurance Policy.

IRS

Means the Internal Revenue Service.

LIFE INSURANCE PLAN COMPONENT

Means the Basic Life Insurance Plan Component and the Voluntary Life Insurance Plan Component.

LONG-TERM DISABILITY PLAN COMPONENT (LTD PLAN COMPONENT)

Means the Plan Component that provides a Participant supplemental income during an extended period of time due to the inability to work as a result of illness, injury, or accident.

PARTICIPANT

Means any Eligible Employee who has satisfied the eligibility requirements of a Plan Component, has been enrolled or elected to enroll in such Plan Component, and has not for any reason become ineligible to continue participation in the Plan Component.

PHSA

Means the Public Health Service Act of 1944 as amended from time to time.

PLAN

Means the Hampden Sydney College Life Accident and Disability Insurance Plan herein adopted by the Employer. The Plan consists of this Basic Plan Document, the corresponding Adoption Agreement, any Component Document, and any attachments or amendments as completed and signed by the Employer, including any amendment provisions adopted prior to the Effective Date of the Plan that are not superseded by the provisions if this is a restatement of an existing plan.

PLAN ADMINISTRATOR

Means the Adopting Employer unless the managing body of the Adopting Employer designates a person or persons other than the Adopting Employer as the Plan Administrator. The managing body of the Adopting Employer may also appoint a successor Plan Administrator. The Adopting Employer will also be the Plan Administrator if the person or persons so designated ceases to be the Plan Administrator and a successor Plan Administrator is not appointed. The Adopting Employer may establish an administrative committee that will carry out the Plan Administrator's duties. Members of the administrative committee may allocate the Plan Administrator's duties among themselves. If the managing body of the Adopting Employer designates a person or persons other than the Adopting Employer as Plan Administrator, such person or persons will serve at the pleasure of the Adopting Employer and will serve pursuant to such procedures as such managing body may provide. Each such person will be bonded if required by law. The Plan Administrator is the named Fiduciary of the Plan for purpose of ERISA section 402(a)(1) with authority to control and manage the operation and administration of the Plan and is responsible for complying with all reporting and disclosure requirements of Part I of Subtitle B of Title I of ERISA.

PLAN COMPONENT

Means each benefit component provided under the Plan as indicated in the Adoption Agreement.

PLAN YEAR

Means the 12-consecutive month period that coincides with the Adopting Employer's tax year or such other 12-consecutive month period as is designated in the Adoption Agreement. Notwithstanding the preceding, a Plan Year may be a period less than 12 months, as defined in the Adoption Agreement.

PREMIUMS

Means the fees paid for the Participant's cost of coverage for a Plan Component.

PROTECTED HEALTH INFORMATION (PHI)

Means Protected Health Information as such term is defined in HIPAA Privacy Rule section 160.103.

QUALIFIED BENEFICIARY

Means an individual as defined in Treasury Regulation section 54.4980B-3 and in parallel continuation coverage requirements under ERISA and the PHSA.

QUALIFYING EVENT

Means an event as defined in Treasury Regulation section 54.4980B-4 and in parallel continuation coverage requirements under ERISA and the PHSA.

SHORT-TERM DISABILITY PLAN COMPONENT (STD PLAN COMPONENT)

Means the Plan Component, other than a state mandated benefit, which provides a Participant the benefit of supplemental income during a limited period of time due to the inability of work as a result of illness, injury, or accident.

SPOUSE

Means an individual who is legally married to a Participant. An individual shall be considered legally married regardless of where the individual is domiciled if either of the following apply: 1) the individual is married in a state, possession, or territory of the United States and the individual is recognized as lawfully married in that state, possession, or territory of the United States; or 2) the individual was married in a foreign jurisdiction and the laws of at least one state, possession, or territory of the United States recognize him or her as lawfully married. Depending on the Plan Component, the term Spouse may include Domestic Partner.

TERMINATION OF EMPLOYMENT

Means a Participant's employment status due to separation of employment. A Participant who does not return to work for the Employer on or before the expiration of an authorized leave of absence from such Employer will be deemed to have incurred a Termination of Employment when such leave ends.

TRUSTEE

Means, if applicable, an individual, individuals, or corporation appointed in a separate trust agreement by the Adopting Employer as Trustee or any duly appointed successor. A corporate Trustee must be a bank, trust company, broker, dealer, or clearing agency as defined in Labor Regulation section 2550.403(a)-1(b). In the event of any conflict between the terms of the Plan and the terms of the separate trust agreement, the terms of the Plan will control.

USERRA

Means the Uniformed Services Employment and Reemployment Rights Act of 1994 as amended from time to time.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT PLAN COMPONENT (VOLUNTARY ADD PLAN COMPONENT)

Means an optional Plan Component paid for by the Employee that expands coverage provided by a Basic ADD Plan Component.

VOLUNTARY LIFE INSURANCE PLAN COMPONENT

Means an optional Plan Component paid for by the Employee that expands coverage provided by a Basic Life Insurance Plan Component.

SECTION ONE: EFFECTIVE DATES

Pursuant to the DEFINITIONS Section of the Plan, the Effective Date means the date the Plan becomes effective as indicated in the Adoption Agreement. However, certain provisions of the Plan may have effective dates different from the Plan Effective Date, if, for example, the Plan is amended after the Effective Date.

SECTION TWO: ELIGIBILITY

2.01. ELIGIBILITY TO PARTICIPATE

An Employee (and their Dependents, unless otherwise elected in the Adoption Agreement or otherwise excluded under the terms of the applicable Component Document) shall become eligible to participate in the Plan as of the first day the Employee becomes eligible under any Plan Component. If elected in the Adoption Agreement and unless otherwise excluded under the terms of the applicable Component Document, the Health Care Plan Component will cover Domestic Partners.

2.02. PLAN ENTRY

- A. Plan Restatement** – If this Plan is an amendment or restatement of a prior Basic Plan Document, each Employee who was a Participant under the prior Basic Plan Document before the Effective Date will continue to be a Participant in this Plan.
- B. Effective Date** – If this is an initial adoption of the Plan by the Employer, an Employee will become a Participant in the Plan as of the Effective Date if the Employee has met the eligibility requirements of Plan Section 2.01 as of such date. After the Effective Date, each Employee will become a Participant on the first Entry Date coinciding with or following the date the Employee satisfies the eligibility requirements of Plan Section 2.01.
- C. Notification** – The Plan Administrator shall notify each Employee who becomes an Eligible Employee under the Plan and shall furnish the Eligible Employee with the enrollment forms or other documents that are required to be completed by the Eligible Employee. Such notification will be in writing, or in any other form permitted under rules promulgated by the IRS or DOL. The Eligible Employee will execute such forms or documents and make available such information as may be required by the Plan Administrator.

2.03. TERMINATION OF PARTICIPATION

The coverage of a Plan participant will terminate in accordance with the terms and conditions set forth in the SPD and Benefit Documents for each applicable Plan Component.

2.04. COBRA CONTINUATION COVERAGE RIGHTS

In the event that participation in a Health Care Plan Component would terminate due to a Qualifying Event, a Participant and/or the Eligible Dependents may have the right to purchase continued coverage for a Health Care Plan Component for a temporary period, as provided under COBRA and any state continuation requirements that are imposed on Insurers that underwrite the insured Plan Components. Continuation coverage rights are explained in detail in the applicable Component Document or in notices related thereto.

2.05. TERMS OF EMPLOYMENT

Nothing with respect to the establishment of the Plan or trust or any action taken with respect to the Plan, nor the fact that an Employee has become a Participant, will give to that Employee any right to employment or continued employment or grant any other rights except as specifically set forth in this Plan, ERISA, or other applicable law or regulation. Furthermore, the Plan will not limit the right of the Employer to discharge an Employee or to otherwise make employment determinations in relation to an Employee without regard to the effect such treatment may have upon the Employee's rights under the Plan.

SECTION THREE: PLAN COMPONENTS AND FUNDING

3.01. PLAN COMPONENTS

The Plan includes various Plan Components as listed on the INSURERS OF PLAN COMPONENTS ATTACHMENT to the Plan's Adoption Agreement. Definitions and the applicable provisions regarding eligibility, coverage, exclusions, and procedures of each Plan Component are contained in the corresponding Component Document.

3.02. FUNDING POLICY

Each Plan Component is either insured or Self-Insured. If Self-Insured, the Plan Component pays benefits through the general assets of the Employer or through a trust. For a list of Plan Components and their funding policy, see the PLAN COMPONENTS AND FUNDING section of the Plan's Adoption Agreement. Benefits under the Plan may be fully funded through Employer Contributions or Participant Contributions or in part by Employer Contributions and Participant Contributions. Such Contributions shall be made in the manner prescribed by the Employer.

3.03. CONTRIBUTIONS

- A. Employee Contributions** – The Employer may require that Participant Contributions be made through payroll deductions. Participant payroll deductions may be included or excluded from their taxable income as determined by the Employer and in accordance with the applicable law or regulation.
- B. Employer Contributions** – The Employer may make its Contributions in an amount that, in the Employer's sole discretion, is sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by Participant Contributions. The Employer may pay its Contribution and Participant Contributions to an insurance carrier or, with respect to those benefits that are Self-Insured, may pay benefits as needed directly from its general assets. The Employer is not contractually obligated to continue Contributions and reserves the right to reduce, suspend, or discontinue any or all Employer Contributions at any time and for any reason.

3.04. TRUST

Except as otherwise required by law, nothing herein will be construed to require the Employer or the Plan Administrator to establish a trust, maintain any fund, or segregate any assets for the benefit of any Participant or Beneficiary, and neither the Participant nor the Beneficiary shall have any claims against, right to, or security or other interest in any fund, account, or asset of the Employer.

Notwithstanding the foregoing, the Adopting Employer may, at its sole discretion or as required by law, establish a trust for the purpose of paying benefits under any Plan Component. All payments of benefits under a Plan Component funded through a trust shall be made out of the trust. Assets held in trust may also be used to pay the Plan's administrative expenses.

If the Adopting Employer establishes a trust for one or more Plan Components, the assets of the Plan corresponding to those Plan Components will be held by the Trustee pursuant to an agreement executed by the Adopting Employer and the Trustee. Assets held by the Trustee will not be earmarked on behalf of any Participant or Beneficiary.

3.05. COST SHARING

The amount of Contributions payable by Participants or Qualified Beneficiaries under a Plan Component may be established by the Adopting Employer at its discretion and revised periodically. However, if a Plan Component is offered as a part of a collective bargaining agreement, the amount of Contributions payable by Participants or Qualified Beneficiaries may be established under the terms of the corresponding collective bargaining agreement.

From time to time the Adopting Employer may, in its sole discretion, establish 1) deductibles, 2) copays or coinsurance, and 3) maximum out-of-pocket amounts. Deductibles, copays, coinsurance, and maximum out-of-pocket amounts may vary among the coverage options available under the Plan Components, among the different features of a single coverage option, among groups of Participants, or in any other manner determined in the discretion of the Adopting Employer. Notwithstanding the foregoing, in no event shall the out-of-pocket limit exceed amounts permissible under PHSA section 2707(b), if applicable.

3.06. PREVAILING WAGES

Plan Components may be used to provide bona fide fringe benefits to comply with any requirement to pay prevailing wages to Employees under any law affecting prevailing wages. If the Employer provides bona fide fringe benefits through one or more Plan Components, it will comply with the terms of the contract to which the Employer is a party and that are subject to the provisions of any prevailing wage law applicable to such offering, including the amount of fringe benefits, payroll withholdings, recordkeeping, and reporting. The Plan is intended to comply with requirements set forth under any applicable prevailing wages law.

SECTION FOUR: CLAIMS AND APPEALS

Participants and Eligible Dependents must comply with the procedures outlined in this section to obtain benefits under the Plan. Unless otherwise stated in the applicable Component Document, the Plan Administrator shall have final authority for adjudicating all Claims and a full review of the decision on such Claims in accordance with the following provisions and with ERISA.

4.01. PLAN COMPONENT CLAIMS AND APPEALS PROCEDURES

Participants and Eligible Dependents must follow the Claims submission rules and Claims appeal procedures contained in the applicable Component Document. Notwithstanding the foregoing, in no event shall the Claims submission rules and Claims appeal procedures contained in the applicable Component Document provide fewer rights to the Participants or Eligible Dependents than the rights prescribed in Labor Regulation section 2560.503-1 and described in this Section Four. If the applicable Component Document does not include Claims and appeals procedures, or if such document includes procedures that do not satisfy the minimum requirements of ERISA, then the Claims and/or appeals will be determined in accordance with this Section Four.

Each Claimant shall be responsible for supplying additional information as required by the Plan Administrator. If the Plan Administrator, in its sole discretion, determines that the Claimant has failed to furnish a required or requested document, no benefits shall be payable under the Plan.

4.02. CLAIMS UNDER DISABILITY PLAN COMPONENT

A. Timing of Claims Decisions – If a Claim is wholly or partially denied, the Plan Administrator shall notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the Claim by the Plan Administrator.

This period may be extended by the Plan Administrator for up to 30 days, provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan Administrator and notifies the Claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Plan Administrator determines that, due to matters beyond its control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrator notifies the Claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan Administrator expects to render a decision. In the case of any extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the Claim, and the additional information needed to resolve those issues. The Claimant shall be afforded at least 45 days within which to provide the specified information.

B. Contents of the Notice of Adverse Benefit Determination – The notice of adverse benefit determination shall, in a manner calculated to be understood by the Claimant, set forth the following:

1. Information sufficient to identify the Claim.
2. The specific reason or reasons for the adverse determination.
3. Reference to the specific Plan provisions on which the determination is based.
4. 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.
5. 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 Plan Administrator 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 Plan Administrator in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or
 - c. a disability determination made by the Social Security Administration regarding the Claimant, presented by the Claimant to the Plan Administrator.
6. If the adverse benefit determination is based on medical necessity, experimental treatment, or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

7. Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist.
8. 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.
9. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on review.

- C. Review of Adverse Benefit Determinations** – The Claimant may request a review of the adverse benefit determination for 180 days following receipt of a notification of an adverse benefit determination. The request for review must be filed in writing with the Plan Administrator. The request for review may include written comments, documents, records, and other information relating to the Claim.

The Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim.

The review of an adverse benefit determination will take into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named Fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named Fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for purposes of a consultation under this paragraph will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

Before the Plan Administrator can issue an adverse benefit determination on review on a disability benefit Claim, the Plan Administrator shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, Insurer, or other person making the benefit determination (or at the direction of the Plan Administrator, Insurer, or such other person) in connection with the Claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under Plan Section 4.02(A) to give the Claimant a reasonable opportunity to respond prior to that date.

Before the Plan Administrator can issue an adverse benefit determination on review on a disability benefit Claim based on a new or additional rationale, the Plan Administrator shall provide the Claimant, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of the adverse benefit determination on review is required to be provided under Plan Section 4.02(A) to give the Claimant a reasonable opportunity to respond prior to that date.

- D. Timing of Review Determinations** – The Plan Administrator shall notify the Claimant of its benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the Claimant's request for review of the initial adverse benefit determination by the Plan Administrator, unless the Plan Administrator determines that special circumstances require an extension of time for processing the Claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render the determination on review.
- E. Contents of the Notice of Adverse Benefit Determination on Review** – The Plan Administrator will provide the Claimant with a notification of the Plan's benefit determination on review. In the case of an adverse benefit determination on review, the notification shall, in a manner calculated to be understood by the Claimant, set forth the following:

1. Information sufficient to identify the Claim.
2. The specific reason or reasons for the adverse determination on review.
3. Reference to the specific Plan provisions on which the benefit determination is based.
4. 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.
5. A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain, upon request, sufficient information relating to the voluntary level of appeal to enable the Claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a Claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the Claimant's rights to any other benefits under the Plan and information about the applicable rules, the Claimant's right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process.

6. A statement of the Claimant's right to bring an action under ERISA section 502(a) with a description of 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 for the Claim.
7. 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 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 Plan in connection with a 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 Plan made by the Social Security Administration.
8. 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 Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
9. Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist.

4.03. CLAIMS UNDER OTHER PLAN COMPONENTS

- A. When Other Plan Component Claims Must Be Filed** – If a Claim is wholly or partially denied, the Plan Administrator shall notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the Claim by the Plan. If the Plan Administrator determines that special circumstances require an extension of time for processing the Claim, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.
- B. Contents of the Notice of Adverse Benefit Determination** – The notice of adverse benefit determination shall, in a manner calculated to be understood by the Claimant, set forth the following:
 1. Information sufficient to identify the Claim.
 2. The specific reason or reasons for the adverse determination.
 3. Reference to the specific Plan provisions on which the determination is based.
 4. 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.
 5. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on review.
- C. Review of Adverse Benefit Determinations** – The Claimant may request a review of the adverse benefit determination within 60 days following receipt of a notification of an adverse benefit determination. The request for review must be filed in writing with the Plan Administrator. The request for review may include written comments, documents, records, and other information relating to the Claim.

The Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim.

The review of an adverse benefit determination will consider all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination.

- D. Timing of Review Determinations** – The Plan Administrator shall notify a Claimant of the Plan's adverse benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the Claimant's request for review by the Plan Administrator, unless the Plan Administrator determines that special circumstances require an extension of time for processing the Claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render the determination on review.
- E. Contents of the Notice of Adverse Benefit Determination on Review** – The Plan Administrator will provide a Claimant with a notification of the benefit determination on review. In the case of an adverse benefit determination on review, the notification shall, in a manner calculated to be understood by the Claimant, set forth the following:
 1. The specific reason or reasons for the adverse determination on review.
 2. Reference to the specific Plan provisions on which the benefit determination is based.

3. 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.

4.04. LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

A Participant may not start a lawsuit to obtain benefits until after the Participant has requested a review and a final decision has been reached on review, or until the appropriate time frames described in Plan Sections 4.02, 4.03, and 4.04, as applicable, have elapsed since the Participant filed a request for review and the Participant has not received a final decision or notice that an extension will be necessary to reach a final decision. The Participant may pursue a remedy under ERISA section 502(a) without exhausting the Plan's appeal procedures if the Plan has failed to follow them. No civil suit may be filed later than 1) one year after the end of the year in which medical reimbursements were provided, or 2) when the Plan rendered its final determination regarding eligibility. All lawsuits must be filed in a federal court where the Plan is administered. For this purpose, a Plan is considered administered at the plan sponsor's business address.

SECTION FIVE: MISCELLANEOUS

5.01. EXCLUSIVE BENEFIT

The Plan has been established for the exclusive benefit of Participants, Eligible Dependents, and Beneficiaries and, except as otherwise provided herein, all Contributions under the Plan may be used only for such purpose.

5.02. PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform and nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Plan Section 5.16.

5.03. POWERS AND DUTIES OF THE PLAN ADMINISTRATOR

A. Powers of the Plan Administrator – The Plan Administrator, under its sole and absolute discretion, shall have the exclusive right, power, and authority to control and manage the operation and administration of the Plan. Without limiting the generality of the foregoing, the Plan Administrator shall have the sole and absolute discretionary authority and power to

1. establish such uniform and nondiscriminatory rules and procedures that it deems necessary to carry out the terms of the Plan;
2. correct any defect, supply any omission, or reconcile any inconsistency in such manner and to such extent as will be deemed necessary or advisable to carry out the purpose of the Plan;
3. formulate, interpret, and apply rules, regulations, and policies necessary to administer the Plan in accordance with its terms;
4. determine questions, including legal or factual questions, relating to the payment of benefits under the Plan;
5. resolve and/or clarify any ambiguities, inconsistencies, and omissions arising under the Plan; and
6. appoint several individuals or entities to assist in the administration of the Plan and allocate the duties of the Plan Administrator among those appointed.

Benefits under the Plan will be paid or provided only if the Plan Administrator decides in its sole and absolute discretion that the Participant or Dependent is eligible to receive them.

All determinations made by the Plan Administrator with respect to any matter arising under the Plan shall be final and binding on all parties and may not be overturned unless found by a court to be arbitrary and capricious.

B. Duties of the Plan Administrator – The Plan Administrator shall be charged with the duties of the general administration of the Plan. Without limiting the generality of the foregoing, the Plan Administrator will

1. administer the Plan for the exclusive benefit of the Participants and Dependents in accordance with the specific terms of the Plan;
2. determine all questions of interpretation or policy in a manner consistent with the Plan's documents;
3. determine all questions relating to the eligibility of Employees to become or remain Participants under the Plan;
4. maintain all records necessary for the administration of the Plan;
5. prepare and file such disclosures and tax forms as may be required from time to time by the Secretary of Labor or the Secretary of the Treasury;
6. furnish each Employee, Participant, or Dependent such notices, information, and reports under such circumstances as may be required by law; and
7. periodically review the performance of each Fiduciary and all other relevant parties to ensure such individuals' obligations under the Plan are performed in a manner that is acceptable under the Plan and applicable law.

C. Nondiscrimination and Consistency Required – Any procedure, discretionary act, interpretation or construction taken by the Plan Administrator shall be done in a uniform and nondiscriminatory manner and shall be consistent with the intent that the Plan shall continue to comply with the Code.

5.04. PLAN AMENDMENTS

- A. General** – The Adopting Employer, at any time and from time to time, may amend or restate any or all of the Plan provisions without the consent of any Participant.
- B. Unilateral Authority** – By adopting the Plan, the Adopting Employer retains the exclusive power and the duty to amend the Plan without any further action or consent of other Related Employers. Specifically, it is understood that amendments may be made unilaterally by the Adopting Employer.
- C. Permitted Amendments** – The Adopting Employer may amend the Plan to 1) change options previously selected in the Adoption Agreement, 2) amend administrative Plan provisions provided the amended provisions are not in conflict with any other Plan provisions, and 3) make amendments that are related to a change in legal requirements.
- D. Administrative Requirements** – An Adopting Employer that wishes to amend the Plan shall document the amendment in writing, executed by a duly authorized officer of the Adopting Employer. If the amendment is in the form of a restated Adoption Agreement, the amendment will become effective on the date provided in the Adoption Agreement. Any other amendment will become effective as described therein upon execution by the Adopting Employer.

5.05. PERMANENCY

The Employer expects to continue this Plan indefinitely, but such continuance is not a contractual obligation. Neither the Adoption Agreement nor the Plan nor any amendment or modification thereof nor the paying of Employer Contributions hereunder will be construed as giving any Participant, or Eligible Dependent or any other person any legal or equitable right against the Employer, any Fiduciary, the Trustee (or Custodian, if applicable), or the Plan Administrator except as specifically provided herein, or as provided by law.

5.06. PLAN TERMINATION

The Adopting Employer is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Adopting Employer (or its successor) reserves the right to terminate the Plan, in whole or in part, at any time by appropriate action of its managing body or a duly authorized officer. Such termination will be effective on the date specified by the Adopting Employer (or its successor). In the event the Plan is terminated, no further reimbursements shall be made except those Claims that were incurred prior to the date of termination.

5.07. CONTINUANCE OF PLAN BY SUCCESSOR EMPLOYER

Notwithstanding the preceding, a successor of the Adopting Employer may continue the Plan and be substituted in the place of the present Adopting Employer. The successor and the present Adopting Employer (or, if deceased, the executor of the estate of a deceased self-employed individual who was the Adopting Employer) must execute a written instrument authorizing such substitution, and the successor shall amend the Plan in accordance with Plan Section 5.04.

5.08. ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

5.09. RIGHT TO RECOVER OVERPAYMENT

Payments are made in accordance with the provisions of the Plan and the applicable Component Document. If it is determined that payment was made for an ineligible charge or that other insurance was considered primary, the Plan Administrator, on behalf of the Plan, has the right to recover the overpayment. The Plan Administrator or a representative of the Insurer or TPA, on behalf of the Plan, will attempt to collect the overpayment from the party to whom the payment was made. However, the Plan Administrator, on behalf of the Plan, reserves the right to seek overpayment from any Participant, Eligible Dependent, Qualified Beneficiary, or Beneficiary. Failure to comply with this request will entitle the Plan Administrator to withhold benefits due to a Participant, Eligible Dependent, Qualified Beneficiary, or Beneficiary or the Employer to withhold wages from a Participant. In addition, the Plan Administrator has the right to engage an outside collection agency to recover overpayments on the Plan's behalf if the Plan Administrator's collection effort is not successful.

The Component Documents may contain information regarding the Plan Administrator's right to subrogate or seek reimbursement of erroneously paid benefits, including payments in excess of the amount appropriately payable, if applicable, to the Plan Component.

5.10. INDEMNIFICATION

To the fullest extent authorized by law, and to the extent not otherwise covered by insurance, the Plan Administrator, officers, and Employees of the Adopting Employer who provide services to the Plan shall be indemnified by the Adopting Employer against any and all liabilities arising by reason of any act, or failure to act, in relation to the Plan including without limitation, expenses reasonably incurred in the defense of any claim relating to the Plan, and amounts paid in compromise or settlement relating to the Plan, unless 1) it is established by a final judgment or a court of competent jurisdiction that such act or failure to act constituted gross negligence or willful misconduct, or 2) in the event of a settlement or other disposition of the claim, it is determined in a written opinion of legal counsel to the Plan that the act constituted gross negligence or willful misconduct.

5.11. NO EMPLOYMENT CONTRACT

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect that such discharge shall have upon him as a Participant of this Plan.

5.12. EXAMINATION OF RECORDS

The Plan Administrator shall make available to each Participant and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

5.13. NO GUARANTEE OF TAX CONSEQUENCES

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes or that any other favorable federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

If a benefit paid under the Plan constitutes gross income for the Participant and is subject to tax liability, the Participant shall not have recourse of any type against the Employer, the Plan Administrator, or Fiduciaries with respect to such tax liability or any expense incurred by the Participant to cover such tax liability.

5.14. HEADINGS

The headings of the Plan have been inserted for convenience of reference only and are to be ignored in any construction of the provisions hereof.

5.15. GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine or neutral gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

5.16. SEVERABILITY

If any clause or Section of the Plan or a Component Document is held invalid or unenforceable, such holding will not affect the validity and enforceability of the remaining clauses or Sections of the Plan or Component Document. The Plan and the Component Document will be interpreted and enforced as if it did not contain the invalid or unenforceable clause.

5.17. GOVERNING LAW

- A. General** – This Plan shall be construed and enforced according to the Code, ERISA, other federal laws and the laws of the state or commonwealth in which the Adopting Employer's principal office is located, other than its laws respecting choice of law, to the extent not preempted by the Code, ERISA, or any other federal law.
- B. Parallel Applicability** – References in the Plan to ERISA shall be deemed to also be references to the corresponding sections of the Code or the PHSA, and vice versa, when applicable.
- C. Conflicting Documents** – The terms of this Basic Plan Document control over any provisions contained in any other document that contravenes or conflicts with the Basic Plan Document.
- D. Health Care Plan Components** – In addition to the general terms of the Plan, the following mandates apply to the Health Care Plan Components, if applicable:
 - 1. Americans with Disabilities Act (ADA) – Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Americans with Disabilities Act (ADA) as amended from time to time.
 - 2. Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – Notwithstanding anything in the Plan to the contrary, to the extent required by Code section 4980B and Treasury Regulations thereunder a Qualified Beneficiary who would lose coverage under the Plan upon the occurrence of a Qualifying Event (as defined in Code section 4980B-3 and parallel ERISA and PHSA sections) shall be permitted to continue coverage under the Plan by electing to pay the applicable cost of coverage, in accordance with procedures established by the Plan Administrator that are consistent with COBRA. The Adopting Employer shall notify each Participant and their Dependents of their rights under COBRA in accordance with applicable law or regulation. If the Employer is a small employer, as defined under COBRA and regulations thereunder, the provision of the preceding paragraph will not apply to the Plan. Notwithstanding the foregoing, COBRA continuation coverage cost will not include unused amounts carried over from the prior year.
 - 3. Extended Coverage Under State Laws – To the extent that the Plan is required under state law to provide extended coverage similar to COBRA, the Plan will comply with the applicable extended coverage requirements. If extended coverage is required under state law, affected individuals, coverage, and duration of extended coverage will be determined by the applicable state law.
 - 4. Family and Medical Leave Act (FMLA) – If the Employer is subject to FMLA, a Participant who is on an approved leave of absence under FMLA will be allowed to maintain coverage under a Health Care Plan Component on the same basis as coverage would have been provided if the Participant had been continuously employed during the entire leave period. Extended coverage of a Health Care Plan Component under FMLA will be provided to the extent required by and in accordance with FMLA and applicable regulations.
 - 5. Title VII of the Civil Rights Act of 1964 – Notwithstanding anything in the Plan to the contrary, the Plan will comply with Title VII of the Civil Rights Act of 1964 as amended from time to time.

6. Uniformed Services Employment and Reemployment Rights Act (USERRA) – Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) as amended from time to time.

5.18. PRIVACY AND SECURITY

A. General – Except for a Health Care Plan Component that is self-administered and has fewer than 50 Participants, the Plan Component will be operated in accordance with HIPAA and the corresponding regulations, as amended from time to time.

B. HIPAA Privacy Standards

1. The authorized representative of the Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Plan Section 5.18(B) are met.
2. Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set forth in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. If the persons to whom information is disclosed violate this Plan Section 5.18(B), or applicable law or regulation, the Plan shall cease disclosing such information.
3. The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform their duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the Employer's control. The Employer shall keep an updated list of those authorized to receive Protected Health Information.
4. Authorized members of the Employer's workforce who receive Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform their duties with respect to the Plan.
5. In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section 6.19 and the HIPAA Privacy Rule, the incident shall be reported to the Plan's Privacy Officer. In addition, the Privacy Officer and the Employer must take the following steps:
 - a. The Privacy Officer must
 - i. investigate the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
 - ii. make appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;
 - iii. mitigate any harm caused by the breach, to the extent practicable; and
 - iv. document the incident and all actions taken to resolve the issue and mitigate any damages.
 - b. The Employer must provide certification to an authorized representative of the Plan that it agrees to
 - i. not use or further disclose the information other than as permitted or required by the Plan or as required by law;
 - ii. ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
 - iii. not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
 - iv. report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section 6.19 or required by law;
 - v. make available Protected Health Information to individual Plan members in accordance with HIPAA Privacy Rule section 164.524;
 - vi. make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with HIPAA Privacy Rule section 164.526;
 - vii. make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with HIPAA Privacy Rule section 164.528;
 - viii. make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule;
 - ix. return or destroy (if feasible) all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

- x. ensure the adequate separation between the Plan and members of the Employer's workforce, as required by HIPAA Privacy Rule section 164.504(f)(2)(iii).
- 6. Failure to comply with the terms of this Plan Section 5.18(B) shall be resolved by persons entitled to use or disclose Protected Health Information in a timely manner.

C. HIPAA Electronic Security Standards

If this Plan is subject to the Security Standards for the Protection of Electronic Protected Health Information (HIPAA Privacy Rule Parts 160, 162, and 164, the "Security Standards"), then this Plan Section 5.18(C) shall apply as follows:

1. The Employer agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of Electronic Protected Health Information that the Employer creates, maintains, or transmits on the Plan's behalf. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
2. The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
3. The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements described in this Plan Section 5.18(C).
4. The Employer will report to the Plan any security incident under the Security Standards of which it becomes aware.
5. The Employer will establish reasonable and appropriate security measures to ensure adequate separation between the Plan and the Employer, in support of the requirements described in this Plan Section 5.18(C).

5.19. NONALIENATION OF BENEFITS

No benefit, right, or interest of any Participant, Eligible Dependent, or Beneficiary under a Plan Component shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities, or other obligations of such person. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, garnish, execute, levy upon, or otherwise dispose of any right to benefits payable hereunder or legal causes of action shall be void. Notwithstanding the foregoing, the Plan may choose to remit payments directly to health care providers with respect to covered services, if authorized by Participants or Eligible Dependents, but only as a convenience to Participants and Eligible Dependents. Health care providers are not, and shall not be construed as, either "Participant" or "Beneficiary" under the Plan and have no right to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) Participants or Eligible Dependents under any circumstances.

5.20. RESPONSIBILITIES OF PARTICIPANT AND BENEFICIARIES

Each Participant and Beneficiary shall be responsible for providing the Plan Administrator, Employer, Insurer, and/or TPA, as applicable, with the Participant's or Beneficiary's current address. In the event that a Participant or Beneficiary becomes entitled to a payment under the Plan and such payment is delayed or cannot be made 1) because the current address according to the Employer's records is incorrect, 2) because the Participant or Beneficiary fails to respond to the notice sent to the current address according to the Employer's records, 3) because of conflicting Claims to such payments, or 4) because of any other reason, the amount of such payment, if and when made, shall be determined under the provisions of the Plan without payment of any interest or earnings. If, after reasonable efforts, the Plan Administrator is unable to locate any Participant or Beneficiary whose benefits under the Plan have become distributable, such benefits may be forfeited in accordance with the terms of the Plan. If the Participant or Beneficiary subsequently applies for benefits, the amount so forfeited will be paid to the Participant or Beneficiary. Notwithstanding the foregoing, with respect to any benefit or arrangement that is underwritten by insurance, the terms of the Insurance Policy shall control to the extent such terms are inconsistent with this Plan Section 5.22.

SECTION SIX: ADOPTING EMPLOYER SIGNATURE

Adoption Agreement must contain the signature of an authorized representative of the Adopting Employer evidencing the Employer's agreement to be bound by the terms of the Basic Plan Document and Adoption Agreement.

Welfare Benefit Plan

Adoption Agreement

WRAP Plan

Hampden Sydney College
Life Accident and Disability Insurance Plan

Hampden Sydney College Life Accident and Disability Insurance Plan

Adoption Agreement

EMPLOYER INFORMATION

Adopting Employer

Name of Adopting Employer: Hampden Sydney College

Address: 201 Cabell Road
PO Box 127
Hampden Sydney, VA 23943

Telephone: 434-223-7724

Adopting Employer's Federal Tax Identification Number: 54-0505906

Adopting Employer's Tax Year End: December 31

Type of Business: Private Sector

PLAN INFORMATION

Amended and Restated Plan

Name of the Plan: Hampden Sydney College Life Accident and Disability Insurance Plan

Plan Number: 501

Plan Year: January 1 through December 31 of the same calendar year.

The Plan originally took effect on: December 31, 2002.

The Effective Date of this Plan is: January 1, 2024.

ELIGIBILITY

Part A. Coverage of Dependents

Will any of the Plan Components cover Dependents?

- ☒ Yes.

Part B. Coverage of Domestic Partners

Will any of the Plan Components cover Domestic Partners?

- ☒ Yes.

NOTE: Notwithstanding the elections made above, if the underlying Plan Component does not extend coverage to Dependents or Domestic Partners, the terms of the underlying Component Document will apply.

PLAN COMPONENTS OFFERED AND FUNDING METHODS

Part A. Life Insurance Plan Components

1. Basic Life Insurance Plan Component

2. Voluntary Life Insurance Plan Component

- Insured. Benefits are provided through an Insurance Policy.

Part B. Accidental Death and Dismemberment Plan Components

1. Basic Accidental Death and Dismemberment Plan Component

2. Voluntary Accidental Death and Dismemberment Plan Component

- Insured. Benefits are provided through an Insurance Policy.

Part C. Short-Term Disability Plan Component

- Insured. Benefits are provided through an Insurance Policy.

Part D. Long-Term Disability Plan Component

- Insured. Benefits are provided through an Insurance Policy.

Part E. Business Travel Accident Plan Component

- Insured. Benefits are provided through an Insurance Policy.

Part F. Employee Assistance Program Plan Component

- Insured. Benefits are provided through an Insurance Policy.

Part G. Voluntary Worksite Benefits Plan Components

- Insured. Benefits are provided through an Insurance Policy.

EMPLOYER SIGNATURE

The following attachment applies to this Plan and is attached to this Adoption Agreement:

- Insurers of Plan Components Attachment.

Authorized Adopting Employer Signature

I am an authorized representative of the Adopting Employer named above and I state the following:

1. I understand that the purpose of this Plan Document is to comply with ERISA;
2. I acknowledge that I have relied upon my own legal and tax advisors regarding the completion of this Adoption Agreement and any related attachments; and
3. I have received a copy of this Adoption Agreement and the corresponding Plan Document.

Signature of Adopting Employer

PK Copeland Jr.

Date Signed

1/11/2024

Type Name

P. Kenneth Copeland, Jr.

Title

Vice Pres. for Business Affairs
& Finance

INSURERS OF PLAN COMPONENTS ATTACHMENT

INSURERS

The Component Documents for each of the Plan Components listed below are incorporated by reference herein and are an integral part of the Plan. This list is subject to modification from time to time in accordance with Plan Section 5.04.

Fully-Insured Benefits	Policy/Group No.	Type of Benefit
Anthem Blue Cross Blue Shield 220 Virginia Ave Indianapolis, IN 46204	—	Employee Assistance Program (EAP)
Hartford Life and Accident Insurance Company One Hartford Plaza Hartford, CT 06155	ETB103109	Business Travel Accident (BTA)
Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10166	5946643	Basic Life/Basic AD&D
		Voluntary Life/AD&D
	211325	Long-Term Disability
		Short-Term Disability
	211325	Voluntary Accident
	211326	Voluntary Critical Illness