THE JOHNS HOPKINS UNIVERSITY LEARNERS' WELFARE PLAN

&

THE JOHNS HOPKINS UNIVERSITY LEARNERS' CAFETERIA PLAN

Amendment and Restatement
Effective July 1, 2023

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THE JOHNS HOPKINS UNIVERSITY LEARNERS' WELFARE PLAN & THE JOHNS HOPKINS UNIVERSITY LEARNERS' CAFETERIA PLAN

Amendment and Restatement
Effective July 1, 2023

PREAMBLE

This amendment and restatement of The Johns Hopkins University Learners' Welfare Plan & The Johns Hopkins University Learners' Cafeteria Plan (hereinafter referred to as the "Plan") is effective July 1, 2023, except as otherwise noted.

ARTICLE 1
DEFINITIONS

Capitalized terms, where capitalized, shall have the meanings set forth in Article I or in an applicable Appendix unless a different meaning is clearly required by the context:

1.1 ADMINISTRATOR means the Plan Administrator referred to in ARTICLE 7.

1.2 APPEALS MANAGER means the persons or entities authorized and responsible for reviewing and determining denied claims and appeals.

1.3 BENEFIT ACCOUNT is defined in Section 4.1.

1.4 BENEFITS means those benefits or coverage available for election by a Participant under Section 4.1.

1.5 CHILD means, except as otherwise provided in a Component Plan:

(i) an individual who is 26 years of age or younger on the last day of the calendar year and who is:

(A) the natural son or daughter of the Participant;

(B) the legally adopted son or daughter of the Participant;

(C) the person legally placed with the Participant for legal adoption, irrespective of whether the adoption has become final;

(D) a stepchild that resides with the Participant;

(E) a child of a Participant's Domestic Partner, provided such child resides with the Participant;

(F) any other individual who, under court order, is in the legal guardianship or legal custody of the Participant. A Child on account of legal guardianship or legal custody shall continue to be treated as a Child

so long as the Child is 26 years of age or younger on the last day of the calendar year and if the legal guardianship or custody relationship is terminated solely on account of the Child reaching the age of majority;

(ii) an individual who has attained age 26 and who is:

(A) either a natural child, legally adopted child, stepchild, Domestic Partner child, or any other child who under court order is in the guardianship or legal custody of the Participant; and

(B) physically or mentally incapable of self-support, with both the Participant and a physician each submitting written proof of the child's incapacity within 30 days after the child reaches 26 or, if later, upon enrollment in the Plan, including verification that such disability commenced prior to age 26.

1.6 CLAIMANT means a Participant or a Participant's Dependent or beneficiary who believes he or she is eligible for any Benefit under the Plan. A Claimant also includes any properly authorized representative (as determined by the Claims Administrator).

1.7 CLAIMS ADMINISTRATOR means the person(s) or entities authorized and responsible for receiving and reviewing claims under the Plan or a Component Plan; determining whether an individual is eligible for benefits; determining what amount, if any, is due and payable; making appropriate disbursements to persons entitled to Plan benefits; and, in the absence of an Appeal Manager, reviewing and determining denied claims and appeals. The Claims Administrator may be the Insurer of a Component Plan.

1.8 CODE means the Internal Revenue Code of 1986, as amended, together with applicable regulations and other authoritative guidance issued thereunder.

1.9 COMPONENT PLAN means any plan or program referred to in ARTICLE 5 and any other plan or program designated by the Plan Sponsor as a Component Plan.

1.10 COVERED PERSON means an individual validly participating in a Benefit option in accordance with the provisions of ARTICLE 2 and applicable administrative materials. A Covered Person may have coverage with respect to certain benefits, but need not have or be eligible for coverage with respect to all benefits described in the Plan

1.11 DEPENDENT means (except as otherwise separately provided under any Component Plan),

(i) for purposes of the medical and dental Component Plans:

(A) The eligible Participant's Spouse;

(B) The eligible Participant's Domestic Partner; and

(C) The eligible Participant's Child.

(ii) for purposes of the employee assistance program:

(A) all household members as defined under that Benefit.

(iii) For purposes of the Plan's Code Section 125 cafeteria plan feature and Health Care FSA, a Dependent is (1) defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and (2) any Child. Notwithstanding the forgoing, the Plan's Code Section 125 cafeteria plan feature will provide Benefits in accordance with the applicable requirements of any qualified medical child support order (as defined in ERISA Section 609), even if the child does not meet the definition of "Dependent."

(iv) For purposes of the Dependent Care FSA, a Dependent means a "qualifying individual" as defined in Code Section 21(b)(1) with respect to the eligible Participant, and in the case of divorced or separated parents, a qualifying individual who is a child shall, as provided in Code Section 21(a)(5), be treated as a qualifying individual of the custodial parent (within the meaning of Code Section 152(e)(3)(A)) and shall not be treated as a qualifying individual with respect to the noncustodial parent.

(v) Additional Rules and Definitions.

(A) A Spouse or Domestic Partner will not qualify as an eligible Dependent if he or she is on active duty in the armed forces of any country. Finally, no Dependent will receive coverage unless the Participant has elected to pay and has paid the required contributions.

(B) Notwithstanding any other provision of this Plan, (i) for purposes of any Component Plan (other than a Health Care FSA) that provides health benefits, if a Dependent is also an Employee, he or she may not be covered as both a Dependent and a Participant at the same time, and (ii) for purposes of any insured benefit offered in a Component Plan, the Insurer's definition of dependent in the insurance contract will prevail and supersede this Plan's definition of Dependent, if different, for purposes of the applicable Component Plan only.

(C) Participants must periodically certify and provide evidence that covered Dependents meet Plan requirements, as requested by the Administrator, in order to maintain coverage. The Administrator, in its discretion, may also conclusively rely on representations from a Participant with regard to any applicable requirement, unless it is unreasonable to do so under the circumstances.

1.12 DEPENDENT CARE FSA means the separate Dependent Care Flexible Spending Account established by the Employer on behalf of an eligible Participant and his or her Dependents as defined and described in Sections 1.11, 5.1(h), and Appendix G. The Dependent Care FSA is not subject to ERISA and not available to Postdoctoral Fellows.

1.13 DOMESTIC PARTNER means an individual of the same or opposite-sex as the Employee who qualifies as the Domestic Partner of the Employee under the Employer's Domestic Partner Policy, which is incorporated into the Plan's Appendix by this reference, but only while he or she continues to qualify as a Domestic Partner, and only after the domestic partnership has been declared in the form and manner required by the Employer.

1.14 EFFECTIVE DATE means July 1, 2023.

1.15 ELECTION FORM means the form provided by or process designated by the Administrator by which an Employee or a Participant enrolls or re-enrolls in the Plan and elects Benefits in accordance with ARTICLE 3.

1.16 EMPLOYEE shall be exclusively determined by the Employer and shall mean a person who is a common law employee on the payroll of the Employer (as determined by the Employer) which may include, but is not limited to, House Staff, clinical fellows, and postdoctoral fellows who receive a wage from the Employer.

(a) Notwithstanding the foregoing, Employee shall not include:

(i) any person who is covered by another welfare and cafeteria plan sponsored by the Employer;

(ii) any person who is deemed a staff member or faculty of the Employer, as determined by the Employer;

(iii) any person who is not a common law employee and not on the payroll of the Employer, such as (a) a medical student, graduate school candidate or graduate school student, (b) a Postdoctoral Fellow who does not receive a wage from the Employer or who is paid through a stipend, (c) trainees, visiting students, or special students, or (d) any other type of person who does not receive a wage from the Employer;

(iv) any employee of the Employer who is a member of a collective bargaining unit covered under a collective bargaining agreement unless the collective bargaining agreement provides for the employee's participation in the Plan;

(v) any person whose compensation is paid by an entity other than the Employer; or

(vi) any person who is a leased employee or a temporary employee of the Employer

(b) If a person who is not eligible for benefits is subsequently reclassified as, or determined to be, an Employee by the Internal Revenue Service, any other governmental agency or authority, or a court, or any other individual or entity, or if an Employer is required to reclassify such a person as an Employee as a result of such reclassification or determination (including any reclassification by the Employer in

settlement of any claim or action relating to such individual's employment status), such a person shall not become eligible to participate in the Plan by reason of such reclassification or determination. If a person who is not classified by the Employer as an Employee otherwise satisfies these eligibility rules and is subsequently reclassified by the Employer as an Employee, such person, for purposes of this Plan shall be deemed an Employee from the later of the actual or the effective date of such reclassification.

1.17 EMPLOYER means The Johns Hopkins University and any other entity that adopts the Plan.

1.18 ERISA means the Employee Retirement Income Security Act of 1974, as amended, together with applicable regulations and other authoritative guidance issued pursuant to that Act.

1.19 HEALTH CARE FSA means the separate Health Care Flexible Spending Account established by the Employer on behalf of an eligible Participant and his or her Dependents as defined and described in Sections 1.11, 5.1(g), and Appendix F. The Health Care FSA is not available to Postdoctoral Fellows.

1.20 HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended, including any applicable regulations and/or rulings issued thereunder.

1.21 HOUSE STAFF means residents and interns who are employees of the Employer.

1.22 INSURER means any insurance company to which premiums are paid and which provides benefits with respect to a Participant in accordance with ARTICLE 5.

1.23 PARTICIPANT means an Employee who becomes a Participant pursuant to ARTICLE 2.

1.24 PARTICIPATION DATE is the first date on which an Employee may participate in the Plan (or a particular Component Plan, if applicable), as set forth in Section 2.2.

1.25 PLAN means, collectively, the Johns Hopkins University Learners Welfare Plan and Cafeteria Plan, as described in this document and as amended from time to time, and the Component Plans.

1.26 PLAN YEAR means the twelve-month period beginning each July 1 and ending each June 30 while this Plan is in effect. Notwithstanding the preceding sentence, for purposes of the Plan's flexible spending account benefits, Plan Year refers to the period of coverage for the flexible spending accounts, which is the calendar year.

1.27 PLAN SPONSOR means The Johns Hopkins University and any successor entity.

1.28 PPACA means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 and any subsequent legislation, together with applicable regulations and other authoritative guidance issued pursuant to that Act.

1.29 SALARY REDUCTION CONTRIBUTIONS mean contributions made under the Plan based on an election (including a deemed election) by an eligible Participant pursuant to Section 4.2 to have amounts withheld from the Participant's compensation on a pre-tax only for House Staff Participants or after-tax basis to pay for benefits or coverage provided under a Component Plan.

1.30 SPOUSE means a person of the same or opposite sex that is married to the Employee pursuant to a legal marriage entered into in a state or other foreign jurisdiction that recognizes such marriage.

1.31 STATUS CHANGE means, and is limited to:

(a) change to an Employee's legal marital status, including marriage, death of Spouse, divorce, legal separation or legal annulment;

(b) change in the number of Dependents, including birth, death, adoption, and placement for adoption (as defined in regulations under Code Section 9801);

(c) change in the Employee or Employee's Dependent's employment status including termination or commencement of employment, change in worksite, reduction or increase in hours of employment (including a switch between part-time and full-time employment, a strike or lockout, or commencement or return from an unpaid leave of absence) and any change in the employment status of an Employee or the Employee's Dependent that results in that person becoming (or ceasing to be) eligible under a plan sponsored by that person's employer;

(d) Dependent satisfying or ceasing to satisfy Dependent eligibility requirements, such as attaining a specified age, student status, or any similar circumstance;

(e) change in residence to an area not covered by the Employee's current Benefit elections;

(f) for purposes of a Component Plan offering dependent care assistance benefits, an event that changes the number of qualifying individuals (as defined under Code Section 21(b)(1));

(g) for any election that is not accomplished on a pre-tax basis, any other event that, in the Administrator's sole discretion, qualifies as a Status Change; or

(h) for an Employee who is eligible to enroll in coverage through a government-sponsored health insurance marketplace during a special or annual enrollment period provided that that the Employee certifies to the Administrator that he and any covered Dependents has obtained minimum essential coverage on the health insurance marketplace immediately upon the cancellation of coverage under this Plan.

1.32 UNIVERSITY means The Johns Hopkins University and any successor entity.

ARTICLE 2
PLAN PURPOSE, ELIGIBILITY AND PARTICIPATION

2.1 PLAN PURPOSE. The purpose of the Plan is to provide a single plan under which the Employer may provide and administer various types of ERISA and non-ERISA welfare benefits for its eligible Employees. For purposes of ERISA, the Plan, including all the programs subject to ERISA, shall comprise a single plan, including for purposes of the reporting requirements under Title I of ERISA (e.g. Form 5500 filings). However, to the extent permitted by Title I of ERISA, the Employer may elect to satisfy the summary plan description and summary of material modifications requirements of ERISA separately with respect to any one or more of the Component Plans. Notwithstanding the foregoing, each individual Component Plan shall be subject to ERISA only to the extent required by ERISA. For purposes of HIPAA, the Plan is a hybrid plan, consisting of programs subject to HIPAA and other programs not subject to HIPAA.

The Plan is intended to qualify as a "medical care plan" under Code Sections 105 and 106, and is to be interpreted in a manner consistent with the requirements of Code Sections 105 and 106. The Plan includes provisions for a "cafeteria plan" meeting the requirements of Code Section 125, but some benefits offered under the Plan (or benefits offered to certain participants) may not be offered pursuant to the Plan's cafeteria plan feature. It is intended that the value of coverage be excluded from the Participants' income under applicable Code Sections, including, but not limited to, Sections 79, 105(b), 106, and 129 and that the Health Care FSA is a limited excepted benefit under Code Section 9831.

Except as otherwise provided, each Component Plan is a separate plan for purposes of satisfying the nondiscrimination requirements of the Code. However, each Component Plan that is a self-insured group health plan, together with any HMO coverage that is offered in lieu of coverage under any such Component Plan, shall constitute a single plan for purposes of the nondiscrimination requirements of Code Section 105(h)(2). It is intended that all applicable nondiscrimination requirements of the Code be satisfied, including all requirements under Code Sections 79, 105(h), 125 and 129 and any nondiscrimination rules issued under the PPACA applicable to fully-insured benefits, to the extent applicable to a particular Component Plan, upon the effective date of such rules.

2.2 COMMENCEMENT OF ELIGIBILITY AND PARTICIPATION. Each Employee is eligible to participate in the Plan beginning on the later of the Effective Date or his or her Participation Date, which will be the date the Employee becomes an Employee.

(a) An individual Component Plan may also impose certain additional or different eligibility and participation requirements as provided therein and incorporated herein by reference.

(b) Each Employee will become a Participant on his or her Participation Date, provided that the Employee completes and submits an Election Form, as applicable to a particular Component Plan or as otherwise required by the Administrator, or is deemed to be enrolled in the Plan pursuant to Section 3.2(b) and provided further that the Employee is an active Employee on that date, as determined by the Employer. If an Employee does

not become a Participant on his or her Participation Date, the Employee will become a Participant on the first day of a Plan Year following his or her completion and submission of an Election Form or, if applicable, the date of coverage resulting from an election pursuant to Section 3.4; provided, however, that, except for Component Plans providing medical coverage, any Employee who does not become a Participant on the earliest possible date under the Plan, and his or her Dependents, may be required by the Employer or the Insurer, at his or her own expense, to submit such proof of good health as the Employer or the Insurer, in its discretion, may require before the Participant or Dependent, as applicable, commences participation in the Plan. The Dependents of a Participant are eligible for benefits under the Plan through and only through the Participant.

(c) This paragraph applies only for purposes of Component Plans providing health benefits that are subject to HIPAA. For purposes of the Plan's requirement that an Employee be an active Employee on his or her Participation Date to become a Participant, an Employee who has commenced employment but who is absent from work on his or her Participation Date because of a health condition, will be treated as an active Employee on that date.

(d) Notwithstanding any other provision of this Plan to the contrary: no person may participate in the Plan's Code Section 125 cafeteria plan feature at any time when he or she does not qualify as a House Staff Employee of the Employer (as determined by the Employer in accordance with Code Section 125(d)(1)(A) and other applicable guidance).

2.3 TERMINATION OF PARTICIPATION.

(a) Termination of Coverage for Participants. Except as otherwise provided herein, a Participant's participation in the Plan terminates on the earliest of the following dates (or, if later, the date described in Section 2.3(a)(iii), if applicable):

(i) The last day of the month in which the Participant terminates employment.

(ii) The last day of the month in which the Participant ceases to qualify as an Employee or a Participant.

(iii) For any coverage requiring Participant contributions, if those contributions are discontinued, the last day of the period for which contributions by the Participant are paid or, if later and if contributions are discontinued because the Participant ceases to qualify as an eligible Employee, the last day of the month in which the Participant ceases to qualify as an eligible Employee.

(iv) The day on which the Participant reports for active duty as a member of the armed forces of any country.

(v) The day on which all Benefits, or the applicable Benefits, are terminated by amendment of the Plan, by whole or partial termination of the Plan or by discontinuation of contributions by the Employer.

(b) Termination of Coverage for Dependents. Except as otherwise provided under Section 2.3(c), a Dependent's participation in the Plan terminates on the earliest of the following dates (or if later, the date described in Section 2.3(b)(iii), if applicable):

(i) The last day of the month in which the Participant terminates employment.

(ii) The last day of the month in which the Participant ceases to qualify as an Employee or a Participant.

(iii) For any coverage requiring Participant contributions, if those contributions are discontinued, the last day of the period for which contributions by the Participant are paid.

(iv) The day on which the Dependent (other than a Dependent described in Section 1.11, for purposes of coverage for which Section 1.11 applies) reports for active duty as a member of the armed forces of any country.

(v) The day on which all Benefits, or the applicable Benefit(s), are terminated by amendment of the Plan, by whole or partial termination of the Plan, by exclusion of the applicable Benefits, or all Benefits, as to Dependents, or by discontinuation of contributions by the Employer.

(vi) The last day of the month in which the Dependent ceases to be a Dependent for any reason other than a Dependent who is covered as a Child of the Participant and reaches age 26.

(vii) The last day of the calendar year in which a Dependent who is covered as a Child of the Participant reaches age 26.

(c) Exceptions. Coverage under a Component Plan may terminate later than as otherwise provided in this Section, in accordance with the following provisions:

(i) USERRA Continuation Coverage. If a Participant takes a leave of absence from employment with the Employer for "service in the uniformed services" as defined in Section 4303(13) of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), he or she may elect to continue to participate in the Plan's medical benefits to the extent required by USERRA Section 4303(7) for the Participant and his or her Dependents, if any. A Participant will be required to pay for such USERRA continuation coverage in an amount determined under USERRA Section 4317(a)(1)(B). USERRA continuation coverage for such a Participant and his or her Dependents, will end on the earlier of: (1) to the extent permitted by USERRA, the date coverage would terminate under Section 2.3(a) or Section 2.3(b) for a reason other than the

Participant's military leave; (2) the last day of the 24 month period beginning on the date on which the Participant's absence begins; or (3) the day on which the Participant fails to apply for or return to a position of employment with the Employer as determined under USERRA Section 4312(e). Notwithstanding the preceding, USERRA continuation coverage under any group health plan (other than a Health Care FSA) that would otherwise terminate earlier than the last day of the month based on events described in items (2) or (3) of the preceding sentence will terminate on the last day of the month in which that event occurs, if such group health coverage usually terminates only on the last day of a month following other termination events (as determined by the Employer).

(ii) COBRA Continuation Coverage. If a Participant or a Dependent is eligible for and elects continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), he or she will remain a participant for purposes of any Component Plan under which continuation coverage is elected while that continuation coverage remains in effect, as determined by the Administrator pursuant to applicable law.

If a Dependent who is covered under the Plan as a Domestic Partner of a Participant or as a Spouse who is a civil union partner of a Participant experiences an event that would qualify as a COBRA qualifying event if the domestic partnership or civil union was considered a marriage for purposes of COBRA, continuation coverage will be offered and, if elected, will be provided in accordance with rules established by the Administrator that generally will be comparable to COBRA rules, including rules for elections and duration and termination of continuation coverage. For purposes of this paragraph, a termination of the domestic partnership or civil union (as determined by the Administrator, in its discretion) will be treated in the same manner as a divorce would be treated for purposes of COBRA coverage.

(iii) Coverage During FMLA Leave. Benefits will be made available during certain periods of leave in accordance with the applicable requirements of the Family and Medical Leave Act of 1993 (FMLA) and any similar applicable state law.

(iv) Coverage During Other Authorized Leave. If a Participant is on an approved leave of absence, coverage will not terminate because of the leave of absence as long as the Participant pays his or her required contributions on time (as determined by the Employer). If the Participant does not return to work or fails to pay any required contributions on time, coverage will be terminated, subject to any COBRA rights or any other provision of this Plan that may provide for continued coverage.

2.4 ELIGIBILITY OF FORMER PARTICIPANTS. If a former Participant becomes an eligible Employee again, his or her Participation Date will be determined under Section 2.2 without regard to any previous period of employment.

Notwithstanding the preceding, a former Participant who becomes an eligible Employee within 30 days after he or she ceased to be a Participant during the same Plan Year may not make a new Code Section 125 pre-tax salary reduction election until the election period for the next Plan Year, except: (i) to the extent that an earlier election change is permitted under Section 3.4 (because of some event other than the termination (or other loss of eligibility) and subsequent return to eligible status) or (ii) to the extent that an election change would have been permitted during an election period that occurred pursuant to Section 3.3 during the period beginning with the Employee's termination of employment or other loss of eligibility and ending on the date the Employee again became an eligible Employee.

ARTICLE 3
ELECTION OF BENEFITS

3.1 ELECTION OF BENEFITS: IN GENERAL. An Employee may elect, on his or her Election Form and in accordance with the following provisions of this Article, any one or more of the Benefits available under ARTICLE 5. The Election Form shall contain such information as the Administrator may deem appropriate.

3.2 INITIAL ELECTION PERIOD.

(a) In General. To become a Participant, an eligible Employee must complete, sign and file an initial Election Form with the Administrator during the Employee's initial "enrollment period" which shall end no more than 30 days after the Employee's hire or appointment date. Any election properly made during the initial enrollment period will be effective, including retroactively if necessary, to the Employee's hire or appointment date, to the extent permitted by applicable law. An eligible Employee that misses the initial enrollment period of 30 days, but enrolls within 60 days after the Employee's hire or appointment date, will be enrolled only on a prospective basis. An Employee who terminates employment and is rehired within 30 days after terminating employment (or who returns to employment following an unpaid leave of absence of less than 30 days) is not a new Employee for purposes of this Section 3.2(a)

The initial coverage period is the period beginning on a Participant's Participation Date and ending on the last day of that Plan Year. The elections made by the Employee on this initial Election Form shall be effective, subject to Section 2.3, from the Participation Date until the last day of the Plan Year during which the Participant changes his or her initial elections pursuant to Section 3.3 or Section 3.4; provided, however, that an Employee's initial election of coverage under a Health Care FSA or Dependent Care FSA will expire no later than the end of the initial Plan Year for which the initial election applies.

(b) Employees Who Fail to File an Initial Election Form. An eligible Employee who fails to complete, sign and file an Election Form with the Administrator before his or her initial coverage period will automatically receive Employer-paid life insurance, long term disability and self-only medical, dental, vision and employee

assistance program coverage (if eligible for those Benefits). The Employee will not automatically participate in any other portion of the Plan or any other Component Plan.

3.3 ELECTION PERIODS AFTER INITIAL ELECTION PERIOD. A Participant's initial elections, with the exception of any Health Care FSA or Dependent Care FSA election, shall continue indefinitely, subject to Sections 2.3 and 3.4, unless one of the following applies:

(a) a change is permitted under the Plan;

(b) a Participant completes and submits a new Election Form during the period designated by the Administrator as the "open enrollment period" preceding the applicable Plan Year. The elections made by the Participant on each such Election Form shall be effective beginning on the first day of the Plan Year following the applicable annual open enrollment period and continuing until such elections are changed pursuant to this section; or

(c) the Employee becomes ineligible under the Plan or any applicable Component Plan.

If a Participant fails to complete and submit an Election Form during the annual open enrollment period, he or she will be deemed to have elected the same Benefits and coverage, or the equivalent as determined in the Administrator's sole discretion, then in effect for that Participant, at the cost determined by the Employer; provided, however, that the Employee shall not be deemed to have elected any coverage under the Health Care FSA or Dependent Care FSA.

Within a reasonable time before the start of a new Plan Year, the Employer may announce and provide for a special mandatory election period for the following Plan Year. In such cases, a Participant's current elections based on a previous Election Form will expire at the end of the current Plan Year and an Employee who fails to submit a valid Election Form during the mandatory election period will not be deemed to have elected any coverage under the Plan, except for Employer-provided coverage under any Component Plan that does not require an affirmative election. The Participant's Election Form during a special mandatory election period shall be effective beginning on the first day of the Plan Year following the applicable election period and continuing until such elections are changed pursuant to this section.

3.4 STATUS CHANGE ELECTIONS; SPECIAL ENROLLMENT; OTHER ELECTION CHANGES.

(a) Status Change Rules. Within 30 days after a Status Change, with the approval of and pursuant to guidelines established by the Administrator and in a manner which is Consistent (as defined below) with the Status Change, (i) a Participant may, change his or her election of Benefits and any salary reduction agreement, and (ii) an Employee who is eligible to become a Participant but has failed to complete an Election Form may become a Participant and file an Election Form. The 30 day period described in the preceding sentence will be extended to 90 days in the case of a Status Change that is birth, adoption, or placement for adoption. Elections made under this section take

effect as soon as practicable after an Election Form is received and approved by the Administrator. Such elections shall remain in effect until the earlier of:

(i) for Health Care FSA or Dependent Care FSA elections, the end of the Plan Year in which the election is made;

(ii) the date on which the Employee becomes ineligible for coverage under any Component Plan; or

(iii) the date the Employee changes his or her election in accordance with the Plan's procedures.

(iv) Except for a change permitted because of a birth, adoption or placement for adoption, any change permitted by this Section 3.4 to an Employee's salary reduction agreement may be made on a prospective basis only and may not be used to pay costs of coverage provided before the effective date of such a change.

(b) "Consistent" Defined. Except as otherwise provided in this Section 3.4(b), an election change is "Consistent" with a Status Change only if the election change is on account of and corresponds with a Status Change that affects the Employee's or the Dependent's eligibility for coverage under the Plan. An election change to decrease or cancel coverage under a Component Plan is not Consistent with a Status Change because of an Employee or a Dependent becoming eligible for coverage under another employer's plan unless the Employee or Dependent actually elects such coverage. In determining whether an election change is Consistent for purposes of the preceding sentence, the Employer may rely on the Employee's certification that alternative coverage has been or will be obtained, unless the Employer has reason to question the accuracy of that certification.

An election change with respect to a Dependent Care FSA is also Consistent with a Status Change if the election change is on account of and corresponds with a Status Change that affects expenses covered under that Component Plan.

(c) HIPAA Special Enrollment Rights. An eligible Employee may revoke an election with respect to group health plan coverage during the Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f) and any regulations thereunder because of the loss of alternate coverage or following a marriage, birth or adoption or placement for adoption, whether or not the change in election would be permitted as a Status Change. The special enrollment period described in this section to make a new election following a birth, adoption or placement for adoption shall be up to a ninety (90) day period following the birth, adoption or placement for adoption. Any requests submitted after ninety (90) days will be treated as an eligibility claim under Section 8.3 and reviewed by the Administrator. Notwithstanding the preceding sentence, any such claim incurred prior to July 10, 2023 may be submitted within thirty (30) days following July 10, 2023, (the last day of the "Outbreak Period" for the novel coronavirus disease (COVID-19) as announced by the

United States Department of Labor, Internal Revenue Service, and Department of the Treasury).

(d) Special Enrollment Rights Relating to Medicaid or CHIP Coverage. Special enrollment rights arise if the eligible Employee's or Dependent's coverage is lost under a Medicaid plan under title XIX of the Social Security Act or a state child health plan under title XXI. The special enrollment period described in this section is the 60-day period that begins on the date of the termination of coverage under a Medicaid plan under title XIX of the Social Security Act or the date the Employee or Dependent is determined by the appropriate government agency to be eligible for the financial assistance. The Employee's elections during the special enrollment period will become effective no later than the first day of the first month beginning after the date the Employee submits to the Administrator and the Administrator receives and approves an Election Form or, if applicable, on an earlier date if the Employer determines coverage must be made effective to comply with Code Section 9801(f)(3). Enrollment under this section is permitted for each Employee or Dependent who experiences an event described above. Enrollment for any person who has not experienced such an event will be permitted under this section only to the extent required by applicable law, as determined by the Administrator. Notwithstanding the 60-day period set forth in Code Section 9801(f), an election under this paragraph that is made prior to July 10, 2023 will be considered timely if it is made within one sixty (60) days following July 10, 2023(the last day of the "Outbreak Period" as announced by the United States Department of Labor, Internal Revenue Service, and Department of the Treasury pertaining to the national emergency concerning the novel coronavirus disease (COVID-19).

(e) Significant Changes in Cost or Coverage. Any election change permitted under this section must be requested, pursuant to procedures established by the Administrator, within a reasonable time after the date of the event giving rise to the right to make the election change (as determined by the Administrator).

(i) Significant Cost Changes. If the cost payable by a Participant for coverage offered under a Benefit option significantly changes during a Plan Year, as determined by the Employer, a Participant may make corresponding changes to his or her election of Benefits and to a salary reduction agreement. If the change is an increase in the Employee's cost of that coverage, a Participant may elect to replace coverage with coverage available under another Benefit option that offers similar coverage, as determined by the Employer, or, if no other similar Benefit option is available, a Participant may cancel the coverage. If the change is a decrease in the Employee's cost of coverage under a Benefit option, a Participant or an Employee who is eligible to become a Participant may elect that coverage.

For purposes of the preceding paragraph, a cost increase or decrease means an increase or decrease in the amount of the Employee's cost for a Benefit option regardless of whether the increase or decrease results from an action taken by the Employee or from an action taken by the Employer.

This subsection does not permit mid-year election changes to the Health Care FSA and only applies to the Dependent Care FSA if the cost change is imposed by a dependent care service provider who is not a "relative" of the Employee. For this purpose, a "relative" is an individual who is related as described in Code Section 152(d)(2)(A) through (G), incorporating the rules of Code Section 152(f)(1) and 152(f)(4).

(ii) Significant Coverage Changes.

(A) Significant Curtailment Without Loss of Coverage. If a Participant or a Dependent experiences a significant curtailment of coverage under a Benefit option that is not a loss of coverage (under applicable law, as determined by the Employer), the Participant may elect to revoke his or her election and elect to receive coverage under another Benefit option, if any, that offers similar coverage, as determined by the Employer, and may make corresponding changes to a salary reduction agreement. Coverage under a Benefit option is significantly curtailed only if there is an overall reduction in coverage that constitutes reduced coverage to Participants generally, as determined by the Employer.

(B) Significant Curtailment With Loss of Coverage. If a Participant or a Dependent experiences a significant curtailment of coverage under a Benefit option that is a loss of coverage (under applicable law, as determined by the Employer), the Participant may elect to revoke his or her election and elect to receive coverage under another Benefit option, if any, that offers similar coverage, as determined by the Employer, and may make corresponding changes to a salary reduction agreement. If no similar coverage is available to replace the Benefit option for which a loss of coverage occurred, a Participant may elect to drop the coverage. Loss of coverage shall be determined in the sole discretion of the Administrator and may include those instances listed in Treasury Regulation Section 1.125-4.

(C) Addition or Improvement of Benefit Option. If the Employer adds a new Benefit option or if coverage under an existing Benefit option is significantly improved during a Plan Year, as determined by the Employer, an eligible Employee may change his or her election of Benefits to replace that Benefit option with the new or improved Benefit option and may make corresponding changes to a salary reduction agreement.

(D) Changes Due to Eligible Changes in Coverage of Spouse, Former Spouse or Other Dependent Under Another Employer's Plan. An eligible Employee may change his or her election of Benefits and salary reduction agreement on account of and corresponding to (A) an election change made during a period of coverage by a Dependent or a former Spouse under a plan sponsored by that person's employer, if the change is

one that is permitted under that employer's plan under provisions similar to the provisions in this section, or (B) an election change made by a Dependent or a former Spouse under a plan sponsored by that person's employer that corresponds to a period of coverage that is different from the Plan Year.

(E) Loss of Other Group Health Coverage. If a Participant, or an Employee who is eligible to become a Participant, or his or her Dependent loses coverage under any group health coverage sponsored by a governmental entity or educational institution, the Participant or Employee may change his or her election of Benefits and salary reduction agreement to elect coverage for the affected individual.

(f) Other Election Changes. Any election change permitted under this section must be requested, pursuant to procedures established by the Administrator, within a reasonable time after the date of the event giving rise to the right to make the election change or as otherwise provided herein.

(i) Judgment, Decree or Order. If a judgment, decree or order (Order) resulting from a divorce, legal separation, annulment, or change in legal custody (including a "qualified medical child support order" defined in ERISA Section 609) requires accident or health coverage for an eligible Employee's child, the Employee, or if required by the Order, the Employer or the Administrator, may change the Employee's election of Benefits and salary reduction agreement to provide coverage for the child if the Order requires coverage under the Plan. If the Order requires the Employee's Spouse, former Spouse or another individual to provide coverage for the child, the Employee may change his or her election of Benefits and salary reduction agreement, if any, to cancel coverage for the child, if the Employee provides adequate proof, as determined by the Administrator, that the coverage required by the Order is actually being provided.

(ii) Medicare/Medicaid Eligibility. If a Participant or a Participant's Dependent who is enrolled in a Component Plan that offers accident or health coverage, becomes enrolled under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Participant may make an election change to cancel or reduce coverage of that Participant, or his or her Dependent, under the Component Plan that offers accident or health coverage, and may change a salary reduction agreement accordingly. If an Employee or an Employee's Dependent, who was previously enrolled under Medicare or Medicaid as described in the previous sentence, loses eligibility for such coverage, the Employee may elect coverage for that individual under a Component Plan that offers accident or health coverage.

(iii) Family and Medical Leave Act. A Participant taking leave under FMLA may revoke an existing election of group health coverage and, upon return

from FMLA leave, may make other elections concerning group health coverage that are permitted by FMLA. A Participant may make corresponding changes to a salary reduction agreement to reflect these special FMLA-permitted changes.

(g) Any other Permitted Status Changes. Notwithstanding anything in this Section 3.4, the Administrator may permit election changes on account of such other status change events as are consistent with Code Section 125 or the regulations promulgated thereunder.

(h) Effective Date of Changes. Any change in an election under this Section 3.4 (except for election changes resulting from termination of Medicaid or CHIP coverage, as described in Section 3.4(d)) shall be effective as soon as administratively practicable on or after the latest of (A) the date on which the Status Change occurs; (B) the date on which the modified Election Form is completed, returned to and approved by the Administrator (which date in the case of an election change causing the addition or deletion of the eligible Employee or Dependent to coverage under the Plan shall in no event be later than 30 days after the event necessitating such election change or 90 days in the case of birth, adoption or placement for adoption; or (C) the date specified by the Participant in his election (which date in the case of an election change causing the addition or deletion of the eligible Employee or Dependent to coverage under the Plan shall in no event be later than 30 days after the event necessitating such election change or 90 days in the case of birth, adoption or placement for adoption).

ARTICLE 4
BENEFIT ACCOUNTS AND SALARY REDUCTION CONTRIBUTIONS

4.1 BENEFIT ACCOUNTS. The Employer or Administrator shall maintain records reflecting a Benefit Account for each Benefit elected by each Participant. Benefit Accounts shall be maintained by the Employer and/or the Administrator as entries on its books. No money shall actually be paid into any Benefit Account. No assets or funds shall be paid to, held in or invested in any separate trust. No interest will be credited to or paid on amounts credited to any Benefit Account.

4.2 SALARY REDUCTION CONTRIBUTIONS. During the applicable election period determined under ARTICLE 3, a House Staff Participant may enter into a salary reduction agreement with the Employer which directs that the Participant's compensation for the period to which the election relates shall be reduced each payroll period and that the amount of such reduction will be credited to the Participant's Benefit Account.

For House Staff Participants who are eligible to participate in the Plan's Code Section 125 cafeteria plan feature, Salary Reduction Contributions will be made on a pre-tax basis to the extent permitted under Code Section 125 (as determined by the Employer) and only from compensation that would otherwise be payable to the Participant as an employee (within the meaning of Code Section 125(d)(1)(A)). For certain Benefits, and to the extent permitted by the Employer, a Participant may make contributions on an after-tax basis and that amount will be credited to his or her Benefit Account. Notwithstanding anything in this Plan to the contrary, only House Staff Participants may make a pre-tax Salary Reduction Contribution.

Except as otherwise provided in this Plan or a Component Plan, a House Staff Participant's pre-tax Salary Reduction Contributions for any period will be limited only by the amount of compensation payable to the Participant as an employee for that period (or the total participant cost of pre-tax benefits elected by the Participant, if less). For purposes of the preceding sentence, "employee" has the same meaning that applies for purposes of Code Section 125(d)(1)(A). Notwithstanding the preceding, the elected salary reduction, as applicable to any Participant, is subject to reduction to the extent deemed necessary by the Administrator to avoid the Plan being discriminatory for purposes of Code Section 125.

Pre-tax Salary Reduction Contributions will be deducted from a Participant's pay on a uniform basis throughout the applicable Plan Year or other period of coverage, with deductions made for each pay period or some other interval that is specified by the Employer. Pre-tax Salary Reduction Contributions deducted from a Participant's compensation during a Plan Year may not be used to pay for coverage or benefits provided during a later Plan Year except to the extent permitted under applicable regulations issued under Code Section 125. As permitted by applicable regulations, in accordance with uniform and consistent administrative and payroll procedures, Salary Reduction Contributions deducted from a Participant's compensation during the last month of a Plan Year may be used to pay for health or accident coverage provided during the first month of the next Plan Year.

A Participant's elected Salary Reduction Contribution for coverage under a Component Plan is subject at all times to the Employer's right to automatically increase or decrease the amount of a Participant's contribution to correspond to a change in the amount that a Participant is required to pay for coverage under that Component Plan. Any automatic changes made based on the preceding sentence will apply prospectively only but otherwise may become effective on any date determined by the Employer. Such automatic changes will be made only on a reasonable and consistent basis.

Except as otherwise expressly permitted under the Plan and applicable law, a Postdoctoral Fellow Participant, a Participant who is on a leave without pay, or any Participant who is not an active Employee shall make contributions on an after-tax basis. Also, any contributions made by or on behalf of a Participant to pay for coverage for any Dependent who is not a Code Section 152 dependent (as defined in Section 1.11), Spouse (as determined for purposes of federal law) or child (as defined in the next sentence) of the Participant will be made on an after-tax basis or, if the Employer in its discretion and in accordance with uniform and consistent administrative procedures, permits such contributions to be made on a pre-tax basis, will be treated as resulting in imputed income for the Participant, to the extent required under applicable law. For purposes of the preceding sentence, "child" means any individual who qualifies as a child of the Participant under Code Section 152(f)(1) who will not reach age 27 before the end of the Participant's tax year.

4.3 ALLOCATIONS TO AND DEBITING OF BENEFIT ACCOUNTS. Amounts shall be allocated to the Benefit Accounts of the Participant and such allocation shall be made pursuant to the election made by the Participant in accordance with Section 5.1. All payments of Benefit amounts under the Plan shall be debited against the appropriate Benefit Account.

4.4 CHANGES DURING PLAN YEAR. Except as provided in Section 3.4 and to the extent permitted under applicable law, a Participant shall not change the allocation of amounts to Benefit Accounts during the Plan Year.

ARTICLE 5
BENEFITS

5.1 AVAILABLE BENEFITS.

The Benefits available for election shall be those provided through the Component Plans. The Participant's cost of the Benefits will be determined by the Employer, and will be communicated to Participants from time to time. Pursuant to a Participant's election of a Benefit, the Participant's compensation be reduced by the amount necessary to provide that Benefit, and the Employer shall credit the amount of the salary reduction to the Component Plan on behalf of the Participant. Without limiting the foregoing, in its sole discretion, the Employer may offer Participants access to an onsite clinic through one or more Component Plan(s). Information related to the onsite medical clinic (including the nature of the benefits provided through the clinic and the costs of such benefits) will be provided to Participants through the applicable Component Plan(s). Benefits and services provided through any such onsite clinic will comply with all relevant provisions of the PPACA, HIPAA, GINA, any other applicable law and related guidance.

The Plan's Benefit options are as follows and as described in the Component Plan(s), which are appended hereto or referenced in the Appendices, and incorporated herein by reference:

(a) Medical Coverage Benefit Account. Each eligible Participant is automatically enrolled in a medical coverage option (including prescription drug coverage) designated by the Employer. Pursuant to the terms of the Component Plan(s), each eligible Participant may elect on his or her Election Form to enroll in one of the dental coverage options designated by the Employer (as those options are described in the Component Plan(s) included in the Appendix) for his or her Dependents. Each eligible Participant may elect on his or her Election Form to enroll in one of the medical coverage options (including prescription drug coverage) designated by the Employer (as those options are described in the Component Plan(s) included in the Appendix). From time to time the Employer may require the Participant to contribute to the cost of medical coverage, in which case, each eligible House Staff Participant may elect to have pre-tax Salary Reduction Contributions and eligible Postdoctoral Fellows may elect to have after-tax Salary Reduction Contributions credited to their Medical Coverage Benefit Account for one of the medical coverage options described above.

(b) Dental Coverage Benefit Account. Each eligible Participant is automatically enrolled in a dental coverage option designated by the Employer. Pursuant to the terms of the Component Plan(s), each eligible Participant may elect on his or her Election Form to enroll in one of the dental coverage options designated by the Employer (as those options are described in the Component Plan(s) included in the Appendix) for his or her Dependents. From time to time the Employer may require the Participant to contribute to the cost of dental coverage, in which case, each eligible House Staff

Participant may elect to have pre-tax Salary Reduction Contributions and eligible Postdoctoral Fellows may elect to have after-tax Salary Reduction Contributions credited to their Dental Coverage Benefit Account for one of the dental coverage options described above.

(c) Vision Coverage Benefit Account. Each eligible Participant is automatically enrolled in a vision coverage option designated by the Employer. Pursuant to the terms of the Component Plan(s), each eligible Participant may elect on his or her Election Form to enroll in one of the vision coverage options designated by the Employer (as those options are described in the Component Plan(s) included in the Appendix) for his or her Dependents. From time to time the Employer may require the Participants to contribute to the cost of vision coverage, in which case, each eligible House Staff Participant may elect to have pre-tax Salary Reduction Contributions and eligible Postdoctoral Fellows may elect to have after-tax Salary Reduction Contributions credited to their Vision Coverage Benefit Account for one of the vision coverage options described above.

(d) Life Insurance Coverage. Each eligible Participant will receive Employer-provided life insurance coverage under a life insurance coverage option designated by the Employer (as that option is described in the Component Plan(s) included in the Appendix).

(e) Short-Term Disability Coverage. Each eligible Participant will receive Employer-provided short-term disability coverage under one of the short-term disability coverage options designated by the Employer (as those options are described in the Component Plan(s) included in the Appendix).

(f) Long Term Disability Coverage. Each eligible Participant will receive Employer-provided long-term disability coverage under one of the long term disability coverage options designated by the Employer (as those options are described in the Component Plan(s) included in the Appendix).

(g) Employee Assistance Program. Each eligible Participant will receive Employer-provided employee assistance program coverage (as described in the Component Plan included in the Appendix).

(h) Health Care FSA (for House Staff Participants Only). Each eligible House Staff Participant shall be entitled to establish a Health Care FSA according to guidelines established by the Administrator (as described in the Component Plan included in the Appendix).

(i) Dependent Care FSA (for House Staff Participants Only); Dependent Care Voucher Program; Backup Childcare Program. The Dependent Care Flexible Spending Account is not intended to be subject to ERISA, even though included as part of a written Plan that may be subject to ERISA. Each eligible House Staff Participant shall be entitled to establish a Dependent Care FSA according to guidelines established by the Administrator (as described in the Component Plan included in the Appendix). House

Staff and salaried Postdoctoral Fellows are eligible to participate in the Employer-provided Dependent Care Voucher Program and Backup Childcare Program as described in the Component Plan included in the Appendix.

(j) Health Coverage Supplemental Fund (for House Staff Medical Plan Participants Only). Each eligible Participant who is enrolled in medical coverage under the Plan will receive Employer-provided cash reimbursement for certain health-related expenses (as described in the Component Plan included in the Appendix.)

(k) Childcare Centers. Each eligible Participant will receive access to our on-site childcare partners: Homewood Early Learning Center, Harry and Jeanette Weinberg Early Childhood Center, and Johns Hopkins Child Care and Early Learning Center (Bright Horizons). Scholarships are available for full-time post-doctoral fellows, doctoral or medical students, and house staff (including residents and interns) based on your family's adjusted gross income. More information is available at: https://hr.jhu.edu/benefits-worklife/family-programs/child-care/jhu-child-care-center-partners/johns-hopkins-child-care-scholarship-details/.

5.2 INSURANCE CONTRACTS. The Employer has the right to enter into contracts with one or more Insurers for the purpose of providing any Benefits under the Plan and to replace any such Insurer from time to time. If any Benefit is intended to be provided under an insurance contract, a Participant or Dependent may look only to the Insurer for payment of that benefit. Any insurance contract between the Employer and an Insurer for the purpose of providing Benefits shall be deemed a Component Plan.

Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any insurance contracts used to provide Benefits shall be the property of, and shall be retained by, the Employer, except to the extent, if any, that the Administrator determines that a portion of the payment is required to be treated as Plan assets under applicable law. To the extent that any portion of such a payment is required to be treated as Plan assets, that amount will be used to pay reasonable Plan expenses or to provide Benefits or will be used for any other purpose that is consistent with applicable law regarding the use of such assets.

5.3 MAXIMUM CONTRIBUTIONS AND BENEFITS. The maximum amount of contributions and Benefits made available under the Plan in any Plan Year shall be limited as provided in the Code.

ARTICLE 6
HEALTH INFORMATION PRIVACY AND SECURITY

6.1 SCOPE OF ARTICLE. This ARTICLE 6 is intended to provide for the Plan's compliance with all applicable requirements of final Regulations issued by the Department of Health and Human Services pursuant to the Administrative Simplification provisions of HIPAA and published as the "Standards for Privacy of Individually Identifiable Health Information" (the Privacy Regulations) and the "Health Insurance Reform: Security Standards" (the Security Regulations) and other applicable guidance, as well as all applicable requirements of Subtitle D of the "Health Information Technology for Economic and Clinical Health Act" (the HITECH

Act) and any authoritative guidance issued pursuant to that Act, if and as they become applicable to the Plan.

Each Component Plan that is a group health plan subject to the Privacy and Security Regulations (each of which is referred to separately in this Article as the "Health Plan") will comply with all applicable requirements of the Privacy Regulations, the Security Regulations and Subtitle D of the HITECH Act, as interpreted pursuant to any authoritative guidance issued by the Department of Health and Human Services. If there is any conflict between the requirements of the Privacy and Security Regulations or Subtitle D of the HITECH Act and any provision of this Plan, applicable law will control. Also, any amendment or revision or authoritative guidance relating to the Privacy and Security Regulations or of Subtitle D of the HITECH Act is hereby incorporated into the Plan as of the date that the Plan is required to comply with that guidance.

6.2 PROTECTED HEALTH INFORMATION. For purposes of the Health Plan, "Protected Health Information" has the same meaning as provided for that term in the Privacy Regulations and is limited to information that is Protected Health Information with respect to the Health Plan.

6.3 DISCLOSURES TO EMPLOYER. The Health Plan will disclose Protected Health Information to the Employer only as follows:

(a) Summary Health Information. The Health Plan, or a health insurance issuer or HMO with respect to the Health Plan may disclose Protected Health Information that is summary health information (as defined in Section 164.504(a) of the Privacy Regulations) to the Employer, if the Employer requests the summary health information for the purpose of:

(i) Obtaining premium bids from insurance issuers for providing health insurance coverage under the Health Plan; or

(ii) Modifying, amending or terminating the Health Plan.

(b) Enrollment Information. The Health Plan, or a health insurance issuer or HMO with respect to the Health Plan, may disclose to the Employer information on whether an individual is participating in the Health Plan, or is enrolled in or has disenrolled from a health option or HMO offered by the Plan.

(c) Other Disclosures to Employer. Except as provided in Sections 6.3(a) and 6.3(b), or under the terms of an applicable individual authorization, the Health Plan may disclose Protected Health Information to the Employer and may permit the disclosure of Protected Health Information by a health insurance issuer or HMO with respect to the Health Plan to the Employer only if the Employer requires the Protected Health Information to administer the Health Plan. The Employer, by signing this Plan document, certifies that it:

(i) will not use or further disclose Protected Health Information other than as permitted by the Health Plan or as required by law;

(ii) will ensure that any agents to whom it provides Protected Health Information received from the Health Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;

(iii) will 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) will report to the Health Plan any use or disclosure, of which it becomes aware, of Protected Health Information that is inconsistent with the uses or disclosures permitted under the Plan;

(v) will make Protected Health Information available to the individual who is the subject of that information in accordance with Section 164.524 of the Privacy Regulations;

(vi) will consider requested amendments to an individual's Protected Health Information in accordance with Section 164.526 of the Privacy Regulations;

(vii) will make available the information required to provide an accounting of disclosures of Protected Health Information in accordance with Section 164.528 of the Privacy Regulations;

(viii) will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Health Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Health Plan with the Privacy Regulations;

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

(x) will ensure that the adequate separation of the Health Plan and the Employer as required in this Article is established.

(d) Prohibited Disclosures. The Health Plan will not disclose Protected Health Information to the Employer for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

6.4 SEPARATION OF HEALTH PLAN AND THE EMPLOYER. The Plan Sponsor has designated and trained certain of its employees in the School of Medicine's Office of the Registrar, the Human Resources Office of Benefit Services, and the Human Resources Benefits Service Center to be the only employees of the Employer who will have access to Protected

Health Information on behalf of the Health Plan. Except as otherwise permitted under applicable law and this Plan, those employees will use or disclose Protected Health Information only to the extent appropriate for performing administrative services that the Employer provides for the Health Plan.

The Employer will work with the Health Plan's designated Privacy Official to establish effective policies and procedures for identifying, investigating, remedying and disciplining any alleged instances of noncompliance with the requirement that employees of the Employer who have access to Protected Health Information use that Protected Health Information only for the purposes specified in this Article.

6.5 PRIVACY NOTICE. The Health Plan will comply with the applicable requirements of the Privacy Notice issued by the Plan pursuant to the requirements of the Privacy Regulations and the Plan's Privacy Notice is incorporated into the Plan by this reference. If the Privacy Notice is revised, the Health Plan will comply with the revised Privacy Notice as of the effective date of the revision. A revised Privacy Notice is incorporated into the Health Plan as of the effective date of each revision without the need for further amendment of the Plan.

6.6 SECURITY REGULATIONS. The Health Plan will comply with all applicable requirements of the Security Regulations, as provided in this Article and in the Security Regulations and as interpreted pursuant to any authoritative guidance issued by the Department of Health and Human Services. If there is any conflict between the requirements of the Security Regulations and any provision of this Plan, the Security Regulations will control. Also, any amendment or revision or authoritative interpretation of the Security Regulations is incorporated into the Plan on the effective date of that guidance.

In addition, the Employer, by adopting this document, certifies that it will:

(i) Reasonably and appropriately safeguard electronic Protected Health Information created, received, maintained, or transmitted to or by the Employer on behalf of the Health Plan;

(ii) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Health Plan;

(iii) Ensure that the adequate separation required by Section 164.504(f)(2)(iii) of the Privacy Regulations is supported by reasonable and appropriate security measures;

(iv) Ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect that information; and

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

6.7 BREACH REPORTING. The Employer will promptly report to the Health Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

ARTICLE 7
ADMINISTRATION

7.1 THE ADMINISTRATOR. Except as to those functions reserved within the Plan or a Component Plan to the Plan Sponsor, a Claims Administrator or an Insurer, the Administrator controls and manages the operation and administration of the Plan and is a "named fiduciary" for purposes of ERISA. The Administrator is the University or any other person, office or committee appointed by the University to administer the Plan. The Administrator or any person who is a member of an office or a committee that is appointed to be the Administrator may or may not be a Participant in the Plan.

7.2 ADMINISTRATIVE RULES AND DETERMINATIONS. Subject to the limitations of the Plan, the Administrator shall establish rules for the administration of the Plan and the transaction of its business. The Administrator has the exclusive right (except as to matters reserved as described in Section 7.1) to interpret the Plan and to decide all matters arising thereunder, including the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Administrator or the Plan Sponsor in respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator has the following powers and duties:

(a) To require any person to furnish such information, including, but not limited to, the execution of any agreements, as the Administrator may request for the purpose of the proper administration of the Plan as a condition to receiving any Benefits under the Plan;

(b) To make and enforce such rules and regulations and prescribe the use of such forms as the Administrator deems necessary for the efficient administration of the Plan;

(c) To decide on questions concerning the Plan and the eligibility of any employee to participate in the Plan, in accordance with the provisions of the Plan; and

(d) To determine the amount of Benefits which shall be payable to any person in accordance with the provisions of the Plan, to inform the Employer of the amount of such Benefits and to provide a full and fair review to any Participant whose claim for Benefits has been denied in whole or in part.

In carrying out its duties herein, the Administrator shall have discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it, and its determinations shall be given deference and shall be final and binding on all interested parties.

Benefits under the Plan will be paid only if the Administrator decides in its discretion that the applicant is entitled to them.

7.3 DELEGATION AND RELIANCE. The Administrator, subject to approval of the University, may employ the services of such entities or persons as it may deem necessary or desirable in connection with the Plan. The Administrator may delegate any of its powers or duties to another person or persons. Without limiting the generality of the preceding sentence, the Administrator shall specifically have the power to delegate to any Claims Administrator the power and responsibility to determine claims and benefits under any policy or third-party administration agreement, and the Administrator shall be protected in relying upon such Claims Administrator determinations. The Administrator and the University (and any person to whom the Administrator may delegate any duty or power in connection with the administration of the Plan) and all persons connected therewith may rely upon all tables, valuations, certificates, reports and opinions furnished by any duly appointed actuary, accountant (including employees of the Employer who are actuaries or accountants) or legal counsel, or other specialist, and they shall be fully protected in respect to any action taken or permitted in good faith in reliance thereon. All actions so taken or permitted shall be conclusive upon all persons.

7.4 INDEMNIFICATION AND INSURANCE. To the extent permitted by law, neither the Administrator, nor any other person performing duties hereunder, shall incur any liability for any act done, determination made or failure to act, if in good faith, and the Employer shall indemnify and defend the Administrator, its members and such other persons (including any Employee serving as a member of a committee designated as Administrator, and including any employee or former employee who formerly performed the duties of Administrator or as a member of such committee) against any and all liabilities, damages, costs and expenses (including reasonable attorneys' fees and amounts paid in settlement of any claims approved by the Employer) which is incurred as a result of the good faith performance or non-performance of their duties hereunder if such acts or omissions were taken or omitted in good faith and is not attributable to the willful malfeasance or gross recklessness. Nothing in this Plan shall preclude the Employer from purchasing liability insurance to protect such persons with respect to their duties under this Plan.

7.5 COMPENSATION, EXPENSES AND BOND. Unless otherwise agreed to by the Plan Sponsor, the Administrator shall serve without compensation for its services as such, but all reasonable expenses incurred in the performance of its duties shall be paid by the Employer. Unless otherwise determined by the Plan Sponsor or unless required by any federal or state law, the Administrator shall not be required to give any bond or other security in any jurisdiction.

7.6 ADMINISTRATIVE EXPENSES PAID BY EMPLOYER. All administrative expenses incurred in connection with the Plan, including but not limited to administrative expenses and compensation and other expenses and charges of any actuary, counsel, accountant, specialist or other person who shall be employed by the Administrator in connection with the Plan, shall be paid by the Employer or from Participant contributions, as determined by the Employer.

ARTICLE 8
CLAIMS PROCEDURES

8.1 CLAIMS PROCEDURES: IN GENERAL. This Article is based on final regulations issued by the Department of Labor and currently codified at 29 C.F.R. Section 2560.503-1 and incorporated herein by reference. If any provision of this Article conflicts with the requirements of those regulations, the requirements of those regulations will prevail. For any insured Benefits offered under the Plan or any Component Plan for which the Administrator has delegated the power and responsibility to determine claims and benefits to a Claims Administrator, the claims procedures established by the Claims Administrator, as applicable, for that benefit will apply instead of the procedures described in this Article except to the extent those procedures conflict with the requirements of applicable law.

Notwithstanding any provision of this Article to the contrary, for any claim for a benefit under the Plan that is not subject to ERISA, the claims procedures for benefits other than health and disability benefits, as described in Section 8.4(a), will apply, except that any requirement to provide notice about any right that may apply under ERISA will not apply to such a claim.

8.2 ADVERSE DETERMINATION. For purposes of this Article, an Adverse Determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in a Component Plan, and including, with respect to any group health plan, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. For purposes of any benefit that is subject to PPACA, Adverse Determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

8.3 ELIGIBILITY CLAIMS. Eligibility claims are those claims related to participation in the Plan or the change of an election to participate during the Plan Year. If a claim relates to enrollment in or eligibility to participate in the Plan (as opposed to what benefits a Participant or his or her Dependents are eligible for under the Plan), the Participant, Dependent or beneficiary shall contact the Administrator to initiate an eligibility claim as soon as possible, but no later than 60 days after eligibility has been denied. The eligibility claim will be reviewed and the Administrator will send a letter stating approval or denial of the eligibility claim within 90 days of receipt. If the eligibility claim is denied on review, the Participant, Dependent or beneficiary may appeal such denial in writing to the Administrator within 60 days of receiving the denial and the Administrator shall make an appeal determination within 60 days. Once the appeal is decided by the Administrator in its sole discretion, that determination is final.

8.4 INITIAL BENEFIT CLAIMS. A Claimant may file a claim with the Claims Administrator. All claims must be submitted in writing, except to the extent oral notice is permitted for certain urgent care health benefit claims, as described in this Article. The Claims Administrator will review the claim itself or appoint an individual or an entity to review the claim. Unless a later deadline expressly applies under a Component Plan, insurance contract, or applicable guidance, no initial claim for any Benefit will be accepted, processed or paid for any

expense if the initial claim is submitted later than one year after the date the expense was incurred.

(a) Non-Health and Non-Disability Benefit Claims. For a claim for a benefit other than a health or disability benefit, the Claimant will be notified within 90 days after the claim is filed whether the claim is allowed or denied, unless the Claimant receives written notice from the Claims Administrator before the end of the 90-day period stating that special circumstances require an extension of the time for decision, such extension not to extend beyond the day which is 180 days after the day the claim is filed.

(b) Health Benefit Claims.

(i) Urgent Care Health Benefit Claims. If a claim is for urgent care health benefits, the Claims Administrator will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claims Administrator will notify the Claimant as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notice may be oral unless written notice is requested by the Claimant. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Administrator will notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

If any person fails to follow the Plan's procedures for submitting an urgent care claim, but provides information to a person or organizational unit that is customarily responsible for handling benefit matters and the information provided identifies a specific Participant or Dependent, a specific medical condition or symptom and a specific treatment, service, or product for which approval is requested; the Administrator or Claims Administrator will notify the potential Claimant, as soon as reasonably possible but no later than 24 hours after the information is provided, of the failure to properly submit a claim and of the proper procedures for submitting the claim. This notice may be oral unless written notice is requested by the Claimant.

A health benefits claim is considered an urgent care claim if applying the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. Notwithstanding the preceding, in determining whether this

section applies to an initial claim for benefits, the Claims Administrator will defer to a determination, if any, by an attending provider that the claim should be treated as an urgent care claim.

(ii) Pre-service Health Benefit Claims. For a pre-service health benefit claim, the Claims Administrator will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Claims Administrator needs additional time to process a claim, the Claimant will be notified, within 15 days after the Plan receives the claim, of those circumstances and of when the Claims Administrator expects to make its decision. Under no circumstances may the Claims Administrator extend the time for making its decision beyond 30 days after receiving the claim. However, if an extension is necessary because the Claimant failed to submit all information necessary to decide the claim, the notice of extension will specifically describe the required information and the Claimant will be afforded at least 45 days from receipt of the notice to provide the specified information.

If any person fails to follow the Plan's procedures for submitting a pre-service health benefit claim, but provides information to a person or organizational unit that is customarily responsible for handling benefit matters and the information provided identifies a specific Participant or Dependent, a specific medical condition or symptom and a specific treatment, service, or product for which approval is requested; the Claims Administrator will notify the potential Claimant as soon as possible but no later than five days after the information is provided, of the failure to properly submit a claim and of the proper procedures for submitting a pre-service claim. The notice may be oral unless written notice is requested by the Claimant.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(iii) Post-service Health Benefit Claims. For a post-service health benefit claim, the Claims Administrator will notify the Claimant of the Plan's Adverse Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to matters beyond the control of the Plan, the Claims Administrator needs additional time to process a claim, the Claimant will be notified, within 30 days after the Claims Administrator receives the claim, of those circumstances and of when the Claims Administrator expects to make its decision. Under no circumstances may the Claims Administrator extend the time for making its decision beyond 45 days after receiving the claim. However, if such an extension is necessary because the Claimant failed to submit all information necessary to decide the claim, the notice of extension will specifically describe the required information and the Claimant will be afforded at least 45 days from receipt of the notice to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment for services which the Claimant has already received.

(iv) Concurrent Care Claims. Notwithstanding any other provision of this Article, if the Plan has previously approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments will constitute an adverse initial benefit determination. These determinations will be known as "concurrent care" decisions. The Claims Administrator will notify the Claimant of an adverse concurrent care decision at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Determination before reduction or termination of the benefit.

Any request by a Claimant to extend a course of urgent care treatment beyond the approved period of time or number of treatments will be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim, provided that the claim is submitted at least 24 hours before the expiration of the prescribed period of time or number of treatments.

(v) Disability Benefit Claims. For a disability benefits claim, the Claims Administrator will notify the Claimant of the Plan's Adverse Determination within a reasonable period of time, but not later than 45 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Claims Administrator needs additional time to process a claim, the Claimant will be notified, within 45 days after the Plan receives the claim, of those circumstances and of the date by which the Plan expects to make its decision, which date will be no later than 75 days after the Plan receives the claim. If the Claims Administrator still needs additional time to process a claim, the Claimant will be notified during the first extension period (i.e., within 75 days after the Plan receives the claim), of those circumstances and of the date by which the Claims Administrator expects to make its decision, which date will be no later than 105 days after the Plan receives the claim. Any extension notice will specifically explain the standards on which entitlement to a disability benefit is based, the unresolved issues that prevent a decision on the claim and any additional information needed from the Claimant to resolve those issues, and the Claimant will be afforded at least 45 days to provide any requested additional information.

(c) Manner and Content of Denial of Initial Claims. If the Claims Administrator denies a claim, it will provide to the Claimant a written or electronic notice that includes:

(i) a description of the specific reasons for the denial;

(ii) a reference to any Plan provision or insurance contract provision upon which the denial is based;

(iii) a description of any additional information or material that the Claimant must provide in order to perfect the claim;

(iv) an explanation of why such additional material or information is necessary;

(v) a statement that the Claimant has a right to request a review of the claim denial and information on the steps to be taken if the Claimant wishes to request a review of the claim denial; and

(vi) if applicable, a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following a denial on review of the initial denial.

(vii) In addition, for a denial of a claim for health benefits or disability benefits, the following must be provided:

(viii) a copy of any rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Determination (or a statement that the same will be provided upon request by the Claimant and without charge); and

(ix) if the Adverse Determination is based on a medical necessity requirement, an experimental treatment exclusion or a similar restriction, either an explanation of the scientific or clinical judgment applying the restriction to the Claimant's medical circumstances or a statement that an explanation will be provided upon request and without charge.

(x) In addition, for a denial of a claim for disability benefits, the following must be provided:

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

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

(C) a statement that the Claimant is entitled to bring a civil action in federal court under Section 502 of ERISA to pursue the Claimant's claim for benefits, and a description of any contractual limitations period that applies to the Claimant's right to bring an action and the calendar date on which the contractual limitations period expires for the claim.

(D) An Adverse Determination shall include rescissions of disability coverage, regardless of whether the rescission had an adverse effect on any particular benefit, unless it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(xi) For any Adverse Determination concerning an urgent care health claim, the information described in this Section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notice in accordance with this Section is furnished not later than three days after the oral notice.

8.5 REVIEW PROCEDURES.

(a) Non-Health and Non-Disability Benefit Claims. A request for review of a denied claim for a benefit other than health or disability benefits must be made in writing to the Appeals Manager within 60 days after receiving notice of denial unless a later deadline expressly applies under a Component Plan, insurance contract, or applicable guidance. The decision upon review will be made within 60 days after the Appeals Manager receives the request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after the request for review is received. A notice of such an extension must be provided to the Claimant within the initial 60-day period and must explain the special circumstances and provide an expected date of decision.

The Appeals Manager will afford the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Appeals Manager. The Appeals Manager will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(b) Health and Disability Benefit Claims. A request for review of a denial of an initial claim for health or disability benefits must be submitted in writing to the Appeals Manager no later than 180 days after the Claimant receives the notice of denial of the initial claim unless a later deadline expressly applies under a Component Plan, insurance contract, or applicable guidance. If a Component Plan provides for two appeals of an Adverse Determination, a request for a second review must be submitted in writing to the Appeals Manager no later than 60 days after the Claimant receives notice

of denial upon the first review unless a later deadline expressly applies under a Component Plan, insurance contract, or applicable guidance.

Notwithstanding the preceding, following a denial of an initial urgent care health benefits claim, the Claimant may request an expedited review of the claim and such a request may be submitted orally or in writing at the discretion of the Claimant. If an expedited review is requested, all necessary information, including the plan's benefit determination on review, will be transmitted between the Appeals Manager and the Claimant by telephone, facsimile, or other available similarly expeditious method, whenever possible.

In addition to providing the Claimant the right to review documents and submit comments as described in (a) above, a review of a denial of a health or disability benefits claim will meet the following requirements:

(i) The Plan will provide a review that does not afford deference to the initial Adverse Determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal and who is not a subordinate of the individual who made the determination.

(ii) The appropriate named fiduciary of the Plan will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination based in whole or in part on a medical judgment, including determinations regarding whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. The professional engaged for purposes of a consultation described in the preceding sentence will be an individual who was not consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual.

(iii) The Plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review, without regard to whether the advice was relied upon in making the benefit review determination.

(iv) For purposes of any benefit option that is subject to PPACA or any disability benefit claims, the Plan or Appeals Manager will allow the Claimant to review the claim file and to present evidence and testimony as part of its internal claims and appeals process and will comply with the following requirements:

(A) The Plan or Appeals Manager will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or Appeals Manager in connection with the claim as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Determination is required to be

provided under this Article (and applicable regulations) to give the Claimant a reasonable opportunity to respond before that date; and

(B) Before the Plan or Appeals Manager issues a final internal Adverse Determination based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale for its decision as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Determination is to be provided under this Article (and applicable regulations) to give the Claimant a reasonable opportunity to respond before that date.

(c) Deadline for Review Decisions.

(i) Urgent Care Health Benefit Claims. For urgent care health claims, the Appeals Manager will notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the Claimant's request for review of the initial Adverse Determination. For any Component Plan that provides for two mandatory levels of internal appeal of an Adverse Determination, such notice will be provided, for each level of appeal, as soon as possible, taking into account the medical exigencies, but not later than 36 hours after Plan receives the Claimant's request for review of the previous Adverse Determination.

(ii) Other Health Benefit Claims.

(A) For a pre-service health claim, the Appeals Manager will notify the Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives the Claimant's request for review of the initial Adverse Determination. For any Component Plan that provides for two mandatory levels of internal appeal of an Adverse Determination, such notice will be provided, for each level of appeal, not later than 15 days after the Plan receives the Claimant's request for review of the previous Adverse Determination.

(B) For a post-service health claim, the Appeals Manager will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after the Plan receives the Claimant's request for review of the initial Adverse Determination. For any Component Plan that provides for two mandatory levels of internal appeal of an Adverse Determination, such notice will be provided, for each level of appeal, not later than 30 days after the Plan receives the Claimant's request for review of the previous Adverse Determination.

(iii) Disability Benefit Claims. For disability claims, the decision on review will be made within 45 days after the Appeals Manager receives a request

for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 90 days after receipt of a request for review. A notice of such an extension will be provided to the Claimant within the initial 45-day period and will explain the special circumstances and provide an expected date of decision.

(d) Manner and Content of Notice of Decision on Review. Upon completion of its review of an initial Adverse Determination, the Appeals Manager will provide the Claimant written or electronic notice of its decision on review. For any Adverse Determination on review, that notice will include:

(i) a description of its decision;

(ii) an explanation of the specific reasons for the decision;

(iii) a reference to any relevant Plan provision or insurance contract provision on which its decision is based;

(iv) a statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the Claim for benefits;

(v) if applicable, a statement describing the Claimant's right to bring an action for judicial review under ERISA Section 502(a);

(vi) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to the Claimant upon request;

(vii) if the Adverse Determination on review is based on a medical necessity requirement, an experimental treatment exclusion or a similar restriction, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that an explanation will be provided without charge upon request; and

(viii) Additionally, for a denial of a claim for disability benefits, the following must be provided:

(A) a discussion of the decision including an explanation of the basis for disagreeing with or not following (i) the views of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant, if those views were presented by the Claimant to the Plan; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in

making the benefit determination; and (iii) a disability determination made on the Claimant's behalf by the Social Security Administration, if that determination was presented by the Claimant to the Plan;

(B) a statement that the Claimant is entitled to bring a civil action in federal court under Section 502 of ERISA to pursue the Claimant's claim for benefits, and a description of any contractual limitations period that applies to the Claimant's right to bring an action and the calendar date on which the contractual limitations period expires for the claim.

8.6 ADDITIONAL NOTICE REQUIREMENTS. For any Adverse Determination involving coverage that is subject to PPACA (or as applicable, for disability benefit claims), any notice of Adverse Determination will include (in addition to other requirements described in this Article):

(a) information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);

(b) as part of the explanation of the Adverse Determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's, Claims Administrator's or Appeals Manager's standard, if any, that was used in denying the claim;

(c) a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(d) information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to PPACA to assist individuals with internal claims and appeals and external review processes; and

(e) a statement describing the availability, upon request by the Claimant, of the diagnosis code (and an explanation of its meaning) and the treatment code (and an explanation of its meaning).

The Plan or Claims Administrator will comply with a request described in paragraph (e) above by providing the requested information as soon as practicable after the Plan receives the request. The Plan or Claims Administrator will not treat such a request as a request for an appeal or for an external review of any Adverse Determination.

Any Adverse Determination regarding coverage that is subject to PPACA or for any disability benefit claims will be provided in a culturally and linguistically appropriate manner in accordance with applicable Regulations or other authoritative guidance regarding such notices.

8.7 AVOIDING CONFLICTS OF INTEREST. For claims involving coverage that is subject to PPACA or for any disability benefit claims, the Plan, Claims Administrator, or Appeals Manager (as applicable) will ensure that claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of individuals involved in claims decisions. Decisions regarding hiring, compensation, termination, promotion, or similar matters will not be made based on the likelihood that any individual involved in making claims decisions will support the denial of benefits.

8.8 CALCULATION OF TIME PERIODS. For purposes of the time periods specified in this Article, the period during which a benefit determination must be made begins when a claim is filed in accordance with Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because a Claimant fails to submit all information necessary for an initial claim for non-urgent care health benefits or for disability benefits, the period for making the determination will be tolled from the date the notice requesting the additional information is sent to the Claimant until the day the Claimant responds.

8.9 FAILURE OF CLAIMANT TO FOLLOW PROCEDURES. Except to the extent that a Claimant is deemed to have exhausted the Plan's claims procedures due to the Plan's failure to follow the claims procedures under ERISA Section 502, a Claimant's compliance with the foregoing provisions of this ARTICLE 8 is a mandatory prerequisite to the Claimant's right to commence any legal action with respect to any claim for Benefits under the Plan.

8.10 PREEMPTION OF STATE LAW. For any insured benefit under this Plan, nothing in this Article shall be construed to supersede any provision of any applicable state law that regulates insurance, except to the extent that such law prevents application of this Article.

8.11 EXTERNAL REVIEW. External review is available for final Adverse Determinations involving (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer, or (2) rescission of coverage (i.e., a retroactive termination of coverage, whether or not the rescission has any effect on any particular benefit at the time). Claimants in urgent care situations and those receiving an ongoing course of treatment may proceed with expedited external review at the same time as the internal appeals process. External review is not available for final Adverse Determinations that relate to a failure to meet the eligibility requirements under the Plan. External review procedures are detailed in the Component Plans.

ARTICLE 9
AMENDMENT OR TERMINATION OF PLAN

9.1 AMENDMENT. The Plan Sponsor, or its delegate, reserves the power at any time and from time to time, and retroactively if deemed necessary or appropriate, to modify or amend, in whole or in part, any or all of the provisions of the Plan or the insurance contracts maintained to provide Benefits under the Plan. No amendment shall deprive any Participant of (i) reimbursement for any expense incurred prior to the date of the amendment if it was theretofore covered by the Plan, or (ii) any Benefit which he or she was entitled to receive under this Plan due to events which all had occurred as of the date of such amendment.

9.2 TERMINATION. The Plan Sponsor reserves the power to discontinue or terminate the Plan at any time. In the event of the dissolution, merger, consolidation or reorganization of the Plan Sponsor, the Plan shall terminate unless it is continued by a successor to the Plan Sponsor.

9.3 REDUCTION OR TERMINATION OF BENEFITS. Participants have no right to Plan Benefits after a Plan termination or a partial Plan termination affecting them, and have no right to Plan Benefits to the extent that they are eliminated or reduced by a Plan amendment. The reservations set forth in this ARTICLE 9 apply to Plan benefits offered or provided to current eligible Employees, future eligible Employees, and former eligible Employees, as well as any other Covered Person. No benefit offered or provided under the Plan is or shall be a vested benefit.

9.4 EFFECTIVE DATES. Any such amendment, discontinuance or termination shall be effective at such date as the Plan Sponsor shall determine.

ARTICLE 10
GENERAL PROVISIONS

10.1 NO EMPLOYMENT CONTRACT. Nothing contained in this Plan shall be construed as a contract of employment between the Employer and any employee, or as a right of any employee to be continued in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its employees with or without cause.

10.2 APPLICABLE LAW AND VENUE. The provisions of the Plan shall be construed, administered and enforced according to applicable federal law and, where not preempted by federal law, the laws of the State of Maryland. The courts of competent jurisdiction in Baltimore, Maryland shall have exclusive jurisdiction for all claims, actions and other proceedings involving or relating to the Plan, including, by way of example and without limitation, a claim or action (i) to recover benefits allegedly due under the Plan or by reason of any law; (ii) to enforce rights under the Plan; (iii) to clarify rights to future benefits under the Plan; or (iv) that seeks a remedy, ruling or judgment of any kind against the Plan or the Administrator or is related in any way to the Plan.

10.3 NON-ALIENATION PROVISIONS.

(a) The right of any Covered Person to: receive any benefit under this Plan, appeal any claim for denied benefits, request copies of Plan documents as permitted by ERISA, and/or bring any legal claim under ERISA, (including but not limited to, claims for Benefits under the Plan, breach of fiduciary duty, statutory penalties) shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind to any third party, including any medical service provider, and any attempt to effect same shall be void. Furthermore, any such right to receive Plan benefits may not be levied upon or otherwise taken or attached by any creditor in any voluntary or involuntary proceeding, and any attempt to cause such right to be so subjected will not be recognized, except to the extent as may be required by law.

(b) Notwithstanding the foregoing:

(i) A Covered Person may direct, in writing, that benefits payable to him or her be paid instead to an institution in which he or she is or was hospitalized, to a provider of medical, dental or vision services or supplies furnished or to be furnished to him or her, or to a person or entity that has provided or paid for, or agreed to provide or pay for, any benefits payable under the Plan. Upon receipt of such direction, the Administrator may, solely for the convenience of a Covered Person, adjudicate claims received from medical providers for services rendered to Covered Persons and direct payment of Plan benefits to said medical provider. A direction to pay a medical provider is not a legal assignment of any benefit or right under the Plan or ERISA, or of any legal or equitable right to institute any court proceeding against the Plan, Plan fiduciaries, or Employer. The Administrator reserves the right to make payment directly to the Covered Person. No payment by the Administrator pursuant to such direction shall be considered an assignment of benefits or as recognition by the Plan of a duty or obligation to pay a provider of medical, dental or vision services or supplies except to the extent the Plan actually chooses to do so.

(ii) Assignment may be permitted to the extent that an applicable Component Plan specifically provides for assignment.

10.4 PAYMENTS TO INCOMPETENTS. If the Administrator knows that any person entitled to payments under the Plan is incompetent by reason of physical or mental disability, age or some other cause, it may cause all payments thereafter becoming due to such person to be made to the person's legal guardian for the person's benefit, without responsibility to follow the application of amounts so paid. Payments made pursuant to this Section shall completely discharge the Administrator and the Employer.

10.5 INABILITY TO LOCATE RECIPIENT. If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person (including a notice of the payment so due mailed to the last known address of such Participant or other person as shown on the records of the Employer), such payment and all subsequent payments otherwise due to such Participant or other person may be forfeited no earlier than 18 months after the date such payment first became due or after such period as is provided in the applicable insurance contract.

10.6 SOURCE OF BENEFITS. The Plan Sponsor (and any insurance contracts purchased or held by the Plan Sponsor) shall be the sole source of Benefits under the Plan. The Plan Sponsor will pay any Benefits intended to be self-funded from its general assets. No Employee or other person shall have any right to, or interest in, any assets of the Plan Sponsor upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the Benefits payable under the Plan to such Employee or other person.

10.7 INTERPRETATION. This Plan is to be interpreted so as to be consistent in all respects with the requirements of the Code and ERISA.

10.8 MISTAKE OF FACT. Any mistake of fact or misstatement of fact shall be corrected and proper adjustment made by reason thereof to the extent practicable, provided that such mistake or misstatement is brought to the attention of the Administrator or its delegate within a reasonable time, not to exceed six (6) months. The Employer shall not be liable in any manner for any determination of fact made in good faith.

10.9 NO VESTED RIGHTS. The Plan creates no vested rights of any kind. No Participant, nor any person claiming through him or her, shall have any right, title or interest in or through the Plan, or part thereof, except as otherwise expressly provided herein. Nothing in the Plan shall be construed as giving any person rights against the Plan, the Plan Sponsor, the Administrator, or any Employer, or any of their employees or agents, except as provided in the Plan.

10.10 WITHHOLDING FOR TAXES. Notwithstanding any other provision of the Plan, an Employer or other organization, insurance company, service provider, or institution providing benefits under the Plan, may withhold from any payment to be made under the Plan such amount or amounts as may be required for purposes of complying with the tax withholding provisions of the Code or any other applicable law.

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

10.12 ENTIRE DOCUMENT. The Plan (including the provisions of any Component Plan), constitutes the entire plan document, and no other written or oral statements shall be deemed or construed to constitute part of the Plan.

10.13 SUBROGATION. This provision applies when a Covered Person (this term refers to Participants and their covered Dependents) receives Plan benefits related to a certain sickness or injury, and separately recovers any amount due to the event which caused such sickness or injury from a third party, including but not limited to tortfeasors, workers compensation programs, uninsured or underinsured motorists programs, no fault or school insurance program, any other insurance policy or other plan of benefits, and/or any other third party, whether by insurance claims payment, lawsuit, settlement, judgment or otherwise. In such instances, the Covered Person is required to reimburse the Plan for amounts paid for claims by the Plan out of any monies recovered from the third party. The Covered Person's receipt of benefits from the Plan means that he agrees to this subrogation and reimbursement provision. The details of this subrogation and reimbursement requirement are as follows:

(a) General Principle. When a Covered Person receives Plan benefits that are also payable under workers' compensation, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, any statute, or when charges or expenses that arise through an act or omission of another person are paid by that person or another third party, whether through insurance claims payment, lawsuit, settlement, judgment or for any other reason, the Covered Person shall reimburse the Plan for the related Plan benefits received out of

any funds or monies the Covered Person recovers from that third party. This is the case regardless of whether the third party recovery is designated for medical costs or expenses.

(b) Specific Requirements and Plan Rights. Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that a Covered Person may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, and even if the Covered Person has not been paid or fully reimbursed for all of his damages or expenses. The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed by the Covered Person have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement. The Plan may enforce its subrogation or reimbursement rights by requiring the Covered Person to assert a claim for any recovery to which the Covered Person may be entitled and which relates to the received Plan benefits. The Plan will not pay attorneys' fees or costs associated with the claim or lawsuit without express written authorization from the Plan Sponsor. If the Plan should become aware that a Covered Person has received a third party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may (i) suspend all further benefits payments related to the Covered Person until the reimbursable portion is returned to the Plan; (ii) offset against amounts that would otherwise be paid to or on behalf of the Covered Person; or (iii) terminate the Covered Person's coverage under the Plan.

(c) Participant Duties and Actions. By participating in the Plan, each Covered Person consents and agrees that, once Plan benefits are paid, a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any payment, settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, each Covered Person agrees to cooperate with the Plan by reimbursing it for Plan benefits received. Once a Covered Person has any reason to believe that he may be entitled to recovery from any third party, the Covered Person must notify the Plan. And, at that time, the Covered Person (and his attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle the Covered Person to any payment amount or recovery from a third party. If a Covered Person fails or refuses to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits to the Covered Person until the agreement is signed. Alternatively, if a Covered Person fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of the Covered Person, the Covered Person's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement, and the Covered Person's agreement to a constructive trust, lien and/or equitable lien by agreement in favor of the Plan on any payment, amount or recovery that the Covered Person recovers from any third person. By accepting

benefits under this Plan, each Covered Person consents and agrees that he shall not assign his rights to settlement or recovery against a third person or party to any other party, including his attorneys, without the Plan's express written consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan. Any funds received by or on behalf of a Covered Person will be treated as being held in constructive trust on behalf of the Plan. A Covered Person may not receive any of the funds until the Covered Person has fully paid the Plan's claims for subrogation and reimbursement.

(d) Right of Recovery. Whenever payments for a claim have been made in excess of the maximum limit for that claim under the Plan, the Plan will have the right to recover such amounts to the extent of the excess from whoever received the excess payment and/or the Participant.

10.14 MEDICARE, MEDICAID AND TRICARE SECONDARY PAYER RULES. The Plan at all times will be operated in accordance with any applicable Medicare and Medicaid secondary payer and non-discrimination rules, including, but not limited to the rules of Section 1144(a) of the Social Security Act. These rules include, where applicable, but are not necessarily limited to, rules concerning individuals with end stage renal disease, rules concerning active employees age 65 or over, and rules concerning working disabled individuals. In addition, the Plan at all times will be operated in accordance with any applicable TRICARE secondary payer and non-discrimination rules issued by the Department of Defense.

10.15 NON-DISCRIMINATION AND OTHER RULES. All benefits and elections under this Plan shall be subject to all applicable non-discrimination and other rules under the Code and other applicable law (e.g., the non-discrimination rules of Code Section 105(h), 125, 129 and 79, the Code Section 125 key employee 25% concentration rules, the Americans with Disabilities Act rules, etc.) and the Employer shall test the Plan for compliance with such rules and may take any actions it considers advisable for the purpose of ensuring the Plan's compliance with such rules.

10.16 HEALTH CARE CONTINUATION COVERAGE RULES. Notwithstanding any provision of the Plan to the contrary, the Employer shall provide Participants and Dependents with all health care continuation coverage rights to which they are entitled under COBRA and any other similar, applicable state law. With respect to the 60-day COBRA election period deadline or 45-day/30-day COBRA premium payment deadlines set forth in Code Section 4980B, a COBRA election or COBRA premium payment that is made prior to the earlier of (a) 1 year from the date that the Participant or Dependent was first eligible for relief, or (b) July 10, 2023 (the last day of the "Outbreak Period" for the national emergency concerning the novel coronavirus disease (COVID-19), as announced by the United States Department of Labor, Internal Revenue Service, and Department of the Treasury), will be considered timely if it is made within sixty (60) days (for a COBRA election), forty-five (45) days (for an initial COBRA premium payment) or thirty (30) days (for COBRA premium payments other than the initial COBRA premium payment) following the earlier of the two dates described in this sub-section.

10.17 WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998. Medical and surgical benefits provided for mastectomies under the Plan will be provided with the Women's

Health and Cancer Rights Act of 1998 (the "Women's Health Act"). In accordance with the Women's Health Act, coverage will be provided for the following:

(a) reconstruction of the breast on which the mastectomy has been performed;

(b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(c) prostheses and coverage for any complications in all stages of mastectomy, including lymphedema.

10.18 NEWBORNS AND MOTHERS' HEALTH PROTECTION ACT OF 1996. Notwithstanding the precertification requirements of the Plan to the contrary, the Plan shall provide maternity care benefits in accordance with the Newborns' and Mothers' Health Protection Act of 1996 (the "Newborn's Act"), effective on the date specified in the Newborn's Act. In accordance with the Newborn's Act, the Plan shall provide benefits for a minimum of 48 hours of inpatient hospital stay for a normal vaginal delivery and a minimum of 96 hours of inpatient hospital stay for caesarean section delivery unless the health care provider and the mother agree that discharge from the hospital shall occur earlier.

10.19 HIPAA RULES. Notwithstanding any provision of the Plan to the contrary, the Plan shall be administered at all times in accordance with all applicable requirements of HIPAA.

10.20 NO GUARANTEE OF TAX CONSEQUENCES. The Administrator shall make no commitment or guarantee that any amounts paid to or for the benefit of a Participant, or any amounts contributed by a Participant pursuant to a Salary Reduction Contribution election will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant.

10.21 STATUTE OF LIMITATIONS. Notwithstanding any otherwise applicable statutory statute of limitations, no legal action may be commenced or maintained to recover benefits under this Plan more than 12 months after the final review decision by the Administrator has been rendered (or deemed rendered) and any such action must be brought in federal district court in the state of Maryland.

10.22 COORDINATION OF BENEFITS. The coordination of benefits provisions specified in the Component Plans, as interpreted by the Administrator in its discretion, shall control coordination of benefits situations involving the Plan and other payers. Notwithstanding any provision of this Plan to the contrary, in any case where a Claimant receives benefits under a Component Plan that could have been paid in part under another plan, the Administrator has the right to seek reimbursement from that other plan.

10.23 HEALTHCARE INTEGRITY AND PROTECTION DATA BANK. To the extent required by Section 221(a) of HIPAA (as codified at 42 U.S.C. Section 1320a-7e) and applicable regulations, the Plan will report any "final adverse action" (as described under those regulations) taken on behalf of a group health plan offered under the Plan to the Healthcare Integrity and Protection Data Bank.

10.24 CLAIMS SUBSTANTIATION REQUIREMENT. All claims for Benefits offered through the Plan's Code Section 125 cafeteria plan feature must be substantiated by information provided by an independent third party in accordance with applicable regulations before benefits may be paid.

10.25 MENTAL HEALTH PARITY. Notwithstanding any provision of the Plan to the contrary, mental health and substance abuse benefits provided under any Component Plan will comply in all respects with all applicable requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, including the following:

(a) Lifetime or Annual Dollar Limits. The Plan will not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

(b) Financial Requirement or Treatment Limitations. The Plan will not apply any financial requirement or treatment limitation (whether quantitative or nonquantitative) to mental health or substance use disorder benefits in any classification (as determined by the Administrator in accordance with applicable regulations) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

(c) Criteria for Medical Necessity Determinations. The criteria for making medical necessity determinations relative to claims involving mental health or substance use disorder benefits will be made available by the Administrator to any current or potential Participant, beneficiary, or in-network provider upon request. The manner in which the foregoing restrictions apply to the Plan will be determined by the Administrator, in its sole discretion, in light of applicable regulations and other guidance.

10.26 GINA. Notwithstanding any provision of the Plan to the contrary, the Plan, including all Component Plans, will comply with the applicable requirements of the Genetic Information Nondiscrimination Act of 2008. The Plan will not use genetic information about any Employee or Dependents for underwriting purposes.

10.27 HEALTH CARE REFORM. Notwithstanding any provision of the Plan to the contrary, the Plan, including all Component Plans, will comply with any applicable requirement of the PPACA beginning on the applicable effective date. The Administrator has designated Utah as the benchmark state.

For any Component Plan that is subject to PPACA, no lifetime limit on essential health benefits will apply and no annual limits on essential health benefits will apply, except to the extent permitted under PPACA and applicable regulations. For purposes of the preceding sentence, "essential health benefits" has the meaning that applies under PPACA and applicable regulations issued pursuant to PPACA, once those regulations are issued and become applicable to the Plan. Notwithstanding the preceding, until regulations defining the term essential health benefits become applicable to the Plan, the Administrator has discretion to interpret that term and any available guidance to determine whether any lifetime or annual limit that might otherwise apply under the terms of any Component Plan is to be disregarded for the Plan to comply with

PPACA. Additionally, the Plan will comply with the following PPACA requirements:

(a) No Preexisting Condition Exclusions. The Plan shall not impose a preexisting condition exclusion under any medical Benefit offered under the Plan.

(b) Preventive Services. Notwithstanding anything in the Plan to the contrary, in-network preventive health services will be covered at 100%. No cost-sharing (e.g., copayments, deductibles, or coinsurance) will apply for these in-network services. Preventive health services have been defined to include the following:

(i) Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;

(ii) Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

(iii) Evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resource and Services Administration ("HRSA") for infants, children and adolescents; and

(iv) Other evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA for women.

(c) Coverage of Clinical Trials. The Plan shall not deny a Participant or a Dependent participation in an approved clinical trial for which such Participant or Dependent is a qualified individual with respect to the treatment of cancer or another life-threatening disease or condition, or deny (or limit or impose additional conditions on) the coverage of routine patient costs for drugs, devices, medical treatment, or procedures provided or performed in connection with participation in such an approved clinical trial. A Participant or Dependent participating in such an approved clinical trial will not be discriminated against on the basis of his participation in the approved clinical trial. For purposes of this Section 10.27(c), the terms "qualified individual," "life threatening disease or condition," "approved clinical trial" and "routine patient costs" shall have the same meaning as found in the Public Health Services Act Section 2709.

(d) Cost-Sharing. The Plan shall comply with the overall cost-sharing limit (i.e., out-of-pocket maximum) mandated by PPACA, indexed annually. For purposes of this provision, cost-sharing includes deductibles, co-insurance, co-payments or similar charges, and any other required expenditure that is a qualified medical expense with respect to essential health benefits covered under the Plan. Cost-sharing shall not include premiums, balance billing amounts for non-network providers or spending for services that are not covered under the Plan.

(e) Medical Loss Ratio Rebates. With respect to any insurance company rebates received by the Plan Sponsor that are subject to the Medical Loss Ratio ("MLR") provisions of PPACA, the Administrator will determine what portion (if any) of such rebate must be treated as "plan assets" under ERISA. If any portion of the rebate must be

treated as plan assets, the Administrator will determine in its sole discretion the manner in which such amounts will be used by the Plan or applied to the benefit of Participants; which Participants need not be the same Participants who made contributions under the policy that issued the rebate. Any portion of the rebate that is not treated as plan assets will be allocated among one or more of Employer(s) as the Plan Sponsor, in its sole discretion, determines appropriate.

(f) Patient Protections. To the extent applicable, group health coverage under the Plan shall comply with the patient protections regarding choice of health care professionals and emergency care services under Public Health Services Act Section 2719A.

(g) Rescission of Coverage. Notwithstanding any provision of the Plan to the contrary, the Plan may rescind coverage under any Component Plan for any individual (or a Participant or Dependent covered under the same coverage as that individual) who engages in fraud with respect to the Plan, or who makes an intentional misrepresentation of material fact. Except as otherwise prohibited by law, the Plan may rescind coverage under a Component Plan for other reasons in accordance with the terms of the applicable Component Plan.

The Plan will not rescind coverage under any Component Plan that is subject to PPACA, for any individual covered under that Component Plan, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud with respect to the Plan, or unless the individual makes an intentional misrepresentation of material fact. In cases where rescission is permitted, the Plan will provide at least 30 days' advance written notice to each Participant or Dependent who would be affected before coverage will be rescinded under this Section. This paragraph is included in the Plan to comply with the requirements of PPACA and applicable regulations, including Treasury Regulations Section 54.9815-2712T (and any subsequent regulations that amend or replace those regulations) and shall be interpreted to be consistent with such regulations and to permit rescissions to the extent permitted under those regulations.

For purposes of this Section, a rescission is a cancellation or discontinuance of coverage under a Component Plan that has retroactive effect. A cancellation or discontinuance of coverage is not a rescission if (i) it is effective retroactively only to the extent it is attributable to a failure to timely pay required participant contributions towards the cost of coverage or (ii) the Administrator determines the Plan is not required by law to treat the retroactive termination as a rescission under applicable law.

IN WITNESS WHEREOF, the Plan Sponsor has caused this document to be executed and its seal to be affixed hereto, effective as specified herein.

ATTEST/WITNESS:

By: Caitlin Busch

Print Name: Caitlin Busch

Date: 6/29/23

THE JOHNS HOPKINS UNIVERSITY

By: [signature]

Print Name: Laurent Heller

Date: 6/29/23

TABLE OF APPENDICES

APPENDIX A

MEDICAL

ANY EVIDENCES OF COVERAGE, CERTIFICATES OF INSURANCE, PLAN DOCUMENTS, AND ANY MEDICAL BENEFIT BOOKLETS ARE INCORPORATED BY REFERENCE INTO THIS APPENDIX A.

APPENDIX B

DENTAL

ANY EVIDENCES OF COVERAGE, CERTIFICATES OF INSURANCE, PLAN DOCUMENTS, AND ANY DENTAL BENEFIT BOOKLETS ARE INCORPORATED BY REFERENCE INTO THIS APPENDIX B.

APPENDIX C

VISION

ANY EVIDENCES OF COVERAGE, CERTIFICATES OF INSURANCE, PLAN DOCUMENTS, AND ANY VISION BENEFIT BOOKLET ARE INCORPORATED BY REFERENCE INTO THIS APPENDIX C.

APPENDIX D

LIFE INSURANCE

ANY EVIDENCES OF COVERAGE, CERTIFICATES OF INSURANCE, PLAN DOCUMENTS, AND ANY LIFE INSURANCE BENEFIT BOOKLET ARE INCORPORATED BY REFERENCE INTO THIS APPENDIX D.

APPENDIX E

LONG TERM DISABILITY

ANY EVIDENCES OF COVERAGE, CERTIFICATES OF INSURANCE, PLAN DOCUMENTS, AND ANY LONG TERM DISABILITY BENEFIT BOOKLETS ARE INCORPORATED BY REFERENCE INTO THIS APPENDIX E.

APPENDIX F

EMPLOYEE ASSISTANCE PROGRAM

ANY EVIDENCES OF COVERAGE, CERTIFICATES OF INSURANCE, PLAN DOCUMENTS, AND ANY EMPLOYEE ASSISTANCE PROGRAM BENEFIT BOOKLET ARE INCORPORATED BY REFERENCE INTO THIS APPENDIX F.

APPENDIX G

HEALTH CARE FSA
(for House Staff Participants Only)

1.1 Election. Each eligible Participant may elect on an Election Form to have Salary Reduction Contributions credited to a Health Care FSA according to guidelines established by the Administrator. The amount of Salary Reduction Contributions that may be credited to a Participant's Health Care FSA for a Plan Year shall be no greater than $3,050 (for 2023, and as adjusted for inflation pursuant to Code Section 125(i)).

1.2 Reimbursements from Health Care FSA. Payments from a Health Care FSA will be made to the Participant as a reimbursement for health-related expenses incurred by the Participant or his or her Spouse or any person who is a dependent of the Participant under Code Section 152 (as modified for purposes of Code Section 105(b)) or any child of the Participant who will be 26 years of age or younger on the last day of the calendar year, that:

(a) Are not covered, paid or reimbursed under any other health plan coverage;

(b) Qualify as expenses for "medical care" (as defined in Code Section 213(d), but excluding qualified long term care expenses (as defined in Code Section 7702B(c)), including "medicine and drugs" (whether or not requiring a prescription) within the meaning of Treasury Regulations Section 1.213-1(e)(2) but only if the medicine or drug is prescribed by a qualified provider (regardless of whether the medicine or drug is available without a prescription) or is insulin;

(c) Are Menstrual Care Products as defined in Code section 223(d)(2)(D);

(d) Qualify as reimbursable medical expenses under Code Section 125; and

(e) Are not taken as a deduction from income on the Participant's federal income tax return in any tax year.

Notwithstanding any provision of the Plan to the contrary, to the extent permitted under applicable regulations issued under Code Section 125, otherwise eligible expenses for orthodontia services that are paid before the services are provided will be treated as incurred at the time that the payment is actually made but only to the extent that the Participant is required to make the advance payment to receive the services.

Notwithstanding any provision in the Plan to the contrary, only expenses incurred during the Plan Year and while the Participant is a Participant for purposes of the Health Care FSA are subject to reimbursement. Any Participant who wishes to receive a reimbursement from his or her Health Care FSA must submit to the Administrator (or its delegate) a request for reimbursement on an approved form provided by the Administrator (or its delegate), along with such evidence as the Administrator requires regarding the amount, nature and payment of such reimbursement. The Administrator (or its delegate) may establish reasonable rules regarding the minimum amount of eligible expenses that must be submitted for reimbursement to be made under the Plan. Unless the Administrator designates a later date, requests for reimbursement must be submitted by April 30

of the calendar year following the calendar year in which the expense was incurred. Notwithstanding the preceding sentence, any such claim incurred during the 2022 Plan Year may be submitted within one hundred and twenty(120) days following July 10, 2023 which is the last day of the "Outbreak Period" as announced by the United States Department of Labor, Internal Revenue Service, and Department of the Treasury.

Requests from a Participant for reimbursement of eligible expenses that exceed the accrued balance in the Participant's Health Care FSA will be paid at any time during the Plan Year upon submission of satisfactory documentation of the expense, but only up to the maximum annual amount elected by the Participant for the Plan Year (plus, if applicable, any remaining amount credited to a Carryover Contribution Subaccount (as described below) at the time of determination), notwithstanding that the Participant's Health Care FSA has not been credited with sufficient Salary Reduction Contributions to cover the reimbursement. Any amount remaining in a Participant's Health Care FSA after the deadline for reimbursement requests for the applicable Plan Year and after all properly submitted reimbursement requests have been paid will be forfeited except to the extent, if any, that the amount is eligible to be treated as a Carryover Contribution for the next Plan Year (as described below).

1.3 Debit Card. The Administrator may permit Participants to use a debit card to pay for eligible expenses that may be reimbursed from the Participant's Health Care FSA. If so, before any Participant receives a debit card, the Participant must agree in writing that he or she will use the card only to pay for eligible medical expenses (as defined in Code Section 213(d) or Code Section 223(d)(2)(D)) of the Participant, his or her Spouse or Dependents, that he or she will not use the debit card for any medical expense that has already been reimbursed, that he or she will not seek reimbursement under any other health plan for any expense paid with a debit card, and that he or she will acquire and retain sufficient documentation (including invoices and receipts) for any expense paid with the debit card. The debit card will include an appropriate statement indicating that, by using the card, the Participant agrees that the card will be used only in accordance with the restrictions described in the previous sentence. In addition, the Plan will comply with all applicable regulations and other authoritative guidance regarding the use of debit cards for Health Care FSA reimbursements, including substantiation requirements and correction procedures in the event that substantiation is not timely provided by the Participants. These correction procedures shall include reporting unsubstantiated amounts as wages on a Participant's Form W-2 where other correction methods fail. To the extent administratively practicable, all correction procedures shall be completed by the last day of the Plan Year.

1.4 Permitted Health Care FSA Carryover Contributions. If a Participant has an unused balance in his or her Health Care FSA on the last day of the Plan Year (the "Original Plan Year"), the amount of the unused balance up to $500 will be treated as a Carryover Contribution for the following Plan Year (the "Carryover Plan Year") and will be added to a Carryover Contribution Subaccount for that Participant under the Health Care FSA, to be available for reimbursement of eligible medical expenses for the Carryover Plan Year.

A Participant's unused balance for purposes of determining the amount of any Carryover Contribution is equal to the maximum annual amount elected by the Participant for the Original Plan Year (plus any amount credited to his or her Carryover Contribution Subaccount at the time of determination) minus the amount of reimbursements paid from the Participant's Health Care

FSA for eligible expenses incurred during the Original Plan Year.

Amounts credited to a Participant's Carryover Contribution Subaccount may be used to pay eligible medical expenses incurred in either (i) the original Plan Year, if the claim is submitted before the applicable deadline for submitting reimbursement requests for that Plan Year, or (2) the Carryover Plan Year (or a later Plan Year, if carried over again). Amounts credited to a Participant's Carryover Contribution Subaccount that are used to pay eligible medical expenses incurred during the Original Plan Year are subtracted from the Carryover Contribution Subaccount and therefore reduce the maximum amount available from the Health Care FSA for the Carryover Plan Year for future claims.

Claims generally will be processed in the order in which they are submitted, so it is the responsibility of the Participant to submit claims for the Original Plan Year first to ensure that the unused balance for the Original Plan Year is used to pay expenses incurred in that year first. However, for the period before the deadline for submitting reimbursement requests for the Original Plan Year, the Plan will treat any payments made for expenses incurred during the Carryover Plan Year as being paid first from the amount the Participant elected to contribute for the Carryover Plan Year before they are paid from the amount credited to the Participant's Carryover Contribution Subaccount.

A Carryover Contribution is not treated as a salary reduction contribution for purposes of the Plan's limit or the Code Section 125(i) limit on Salary Reduction Contributions to a Health Care FSA for a Plan Year.

1.5 Qualified Reservist Distributions. Notwithstanding any provision of this Plan to the contrary, the Plan will permit "qualified reservist distributions" from a Health Care FSA of eligible Participants in accordance with the provisions of this Appendix and Code Section 125(h).

A "qualified reservist distribution" is a distribution to an individual of all or a portion of the balance in a Health Care FSA if: (1) the individual is a member of a reserve component ordered or called to active duty for a period of 180 days or more or for an indefinite period; and (2) the distribution is made during the period beginning on the date of the call to active duty, and ending on the last date that reimbursements could otherwise be made under the Health Care FSA for the Plan Year that includes the date of the call to active duty.

An eligible Participant may request a qualified reservist distribution at any time between the date of the order or call to active duty and the last day of the Plan Year in which the call or order to active duty occurred. Qualified reservist distributions will be available to all Participants in the Plan on a uniform and consistent basis. The Employer may establish uniform and consistent administrative procedures for requesting a qualified reservist distributions and may require that the Participant provide such evidence, including a copy of the order or call to active duty, as is needed to verify that a Participant is eligible for such a distribution. A qualified reservist distribution will be paid to the eligible Participant within a reasonable time (and no later than 60 days) after the Participant has submitted a proper request for a distribution. A qualified reservist distribution will be treated as taxable compensation to the Participant (except as

otherwise provided under applicable law, including to the extent that any portion of the distribution is attributable to after-tax contributions).

If a Participant requests a qualified reservist distribution, any claims for reimbursement from the Health Care FSA for eligible medical expenses incurred before the date of the request will be processed and paid in accordance with standard procedures claims until the qualified reservist distribution is made. Reimbursements or payments made through the Health Care FSA for eligible medical expenses during the period between the time a distribution is requested and the date the distribution is made will reduce the amount available for a qualified reservist distribution as described in the definition of unused balance above. Claims for Health Care FSA reimbursements for otherwise eligible medical expenses incurred after the date the Participant requests a qualified reservist distribution will not be paid unless the Participant's request for a distribution is denied. After a qualified reservist distribution equal to the Participant's entire Health Care FSA balance has been made, the Participant will cease to be a Participant for purposes of the Health Care FSA for the Plan Year and no further claims will be paid, regardless of the date an expense was incurred.

APPENDIX H

DEPENDENT CARE FSA (for House Staff Participants Only)
DEPENDENT CARE VOUCHER PROGRAM
BACKUP CHILDCARE PROGRAM

1.1 Childcare Benefits Not Subject to ERISA.

The Dependent Care Flexible Spending Account ("Dependent Care FSA"), Dependent Care Voucher Program, and Backup Childcare Program are not intended to be subject to ERISA, even though they are included as part of a written Plan that may be subject to ERISA.

1.2 Election.

Each eligible House Staff Participant may elect on an Election Form to have Salary Reduction Contributions in an aggregate amount not to exceed $5,000 per calendar year (or, for a married Participant filing a separate return for the taxable year in question, $2,500 per calendar year) credited to the Participant's Dependent Care FSA according to guidelines established by the Administrator. Notwithstanding the foregoing, with respect to the Backup Childcare Program only, these amounts shall be increased to $10,500 (or for a married Participant filing a separate return for the taxable year in question, $5,250) for the 2021 Plan Year. Payments from the Dependent Care FSA shall be made to the House Staff Participant in the form of an Employer-provided payment in accordance with the following provisions which the Employer intends will be interpreted in a manner which is consistent with Code Section 129. Notwithstanding the foregoing, such House Staff Participant election for the Dependent Care FSA may be limited based on eligibility for and enrollment in the Plan Sponsor's Dependent Care Voucher Program and/or Backup Childcare Program.

1.2 Reimbursements from Dependent Care FSA.

A Participant is eligible to receive reimbursement for Employment Related Expenses (as defined below) incurred during the applicable Plan Year and while he or she is a Participant for purposes of the Dependent Care FSA.

(i) The aggregate amount of reimbursements from the Dependent Care FSA which may be received by the Participant on a tax-free basis shall not exceed the Earned Income (as defined below) of the Participant, or, if the Participant is married at the end of the Participant's applicable tax year, the Earned Income of the Participant's Spouse, if less. Any amount of reimbursement received from the Dependent Care FSA during the Participant's tax year that exceeds the lesser of the Earned Income of the Participant or, if the Participant is married at the end of that tax year, the Earned Income of the Participant's Spouse, shall be taxable to the Participant.

(ii) Employment Related Expenses that are incurred for services outside the Participant's household will be entitled to reimbursement only:

(A) if incurred for the care of (i) a Qualifying Individual who is

a "qualifying child" (within the meaning of Code Section 152) under 13 years of age or, for the 2020 Plan Year or the 2021 Plan Year (with respect to unused 2020 Dependent Care FSA amounts) under the age of 14, or (ii) another Qualifying Individual who regularly spends at least eight hours each day in the Participant's household; or

(B) if incurred for services performed outside the Participant's household by a Dependent Care Center (as defined below), only if such Center complies with the applicable laws and regulations of a state or unit of local government and care is rendered to (i) a Qualifying Individual who is a qualifying child (within the meaning of Code Section 152) of the Participant under 13 years of age or, for the 2020 Plan Year or the 2021 Plan Year (with respect to unused 2020 Dependent Care FSA amounts) under the age of 14, or (ii) another Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. A "Dependent Care Center" means any facility that (a) provides care for more than six individuals (other than individuals who reside at the facility), and (b) receives a fee, payment or grant for providing services for any of the individuals (regardless of whether such facility is operated for profit).

(iii) Notwithstanding any provision of the Plan to the contrary, no payments shall be made to a Participant for Employment Related Expenses for services rendered by an individual:

(A) for whom the Participant or his or her Spouse (determined under federal law) is entitled to a deduction under Code Section 152(c) for the applicable tax year of the Participant or Spouse, or

(B) who is a son, stepson, daughter, stepdaughter or foster child of the Participant who will be under the age of 19 at the end of the tax year of the Participant during which the services are performed.

(iv) Notwithstanding any provision of the Plan to the contrary, only expenses incurred during the Plan Year and while the Participant remains a Participant for purposes of the Dependent Care FSA are subject to reimbursement.

(v) Any Participant who wishes to receive a reimbursement from his or her Dependent Care FSA must submit to the Administrator a request for reimbursement on a form provided by the Administrator, along with such evidence as the Administrator requires regarding the amount, nature and payment of such reimbursement. The amount of any reimbursement may not exceed the remaining amount credited to the Participant's Dependent Care FSA at the time the claim for reimbursement is submitted. Requests from a Participant for reimbursement of eligible expenses which exceed the accrued balance in the Participant's Dependent Care FSA will be held until the Dependent Care FSA Account has been credited with sufficient amounts to permit such reimbursement, provided that such additional credits are made within the Plan Year in which the expense was incurred. The Administrator may establish reasonable rules regarding the minimum amount of eligible expenses that must be submitted for reimbursement to be made under the Plan. Unless the Administrator designates a later date, requests for reimbursement must be submitted by April 30 of the calendar year following the calendar year in which the expense was incurred. Any

amount remaining in a Participant's Dependent Care FSA after the deadline for reimbursement requests for the applicable Plan Year and after all properly submitted reimbursement requests have been paid will be forfeited. Notwithstanding the preceding sentence, for the 2020 and 2021 Plan Years only, the entire unused balance credited to the Participant's Dependent Care FSA shall be available in the subsequent Plan Year (i.e. a 12 month extended grace period) and may reimburse the Participant for reimbursement of eligible expenses incurred either during the 2021 or the 2022 Plan Year.

(vi) On or before each January 31 during which this Plan is in effect, the Administrator shall furnish to each Participant a written statement, which may be the Participant's W-2, showing the amounts paid or expenses incurred by the Employer in providing dependent care assistance to such Participant during the previous calendar year.

(vii) No amount will be reimbursed to a Participant unless he or she provides the Administrator with the name, address and tax identification number of the person performing services or if the service provider is an organization exempt under Code Section 501(a), the name and address of such service provider. This provision will not apply if the Participant exercises due diligence in attempting to provide this information.

1.3 Treatment of Forfeitures in Dependent Care FSA.

Notwithstanding any provision of the Plan to the contrary, to the extent permitted under applicable regulations issued under Code Section 125 and in the Administrator's sole discretion, Dependent Care FSA experience gains attributable to one or more Plan Years may either be retained or allocated as set forth in Proposed Treasury Reg. § 1.125-5(o).

1.4 Definitions. For purposes of this Appendix, the following terms shall have the following meanings:

(i) "Backup Childcare Program" means the childcare benefit offered by the Employer, as such program is set forth and amended from time to time at https://hr.jhu.edu/benefits-worklife/family-programs/child-care/backup-care/.

(ii) "Dependent Care Voucher Program" means the childcare benefit offered by the Employer, as such program is set forth and amended from time to time at https://hr.jhu.edu/benefits-worklife/family-programs/child-care/2020-dependent-care-voucher/.

(iii) "Earned Income" means wages, salaries, tips and other employee compensation, including net earnings from self-employment, for the tax year of the Participant (computed without regard to any community property laws), and excluding pension and annuity income and income as a non-resident alien not connected with a United States business. The Earned Income of a Spouse who is a full-time student at an educational institution or who is physically or mentally incapable of self-care is deemed to be not less than $250 per month if there is one Qualifying Individual (as defined below) or $500 per month if there are two or more Qualifying Individuals.

(iv) "Employment Related Expenses" for which reimbursement may be

made from the Dependent Care FSA are amounts paid by the Participant for:

(A) expenses for Household Services (as defined below); and

(B) expenses for the care of a Qualifying Individual;

so long as such expenses are incurred to enable the Participant or the Participant's Spouse to be gainfully employed for a period for which there is at least one Qualifying Individual with respect to the Participant.

(v) "Household Services" means ordinary and usual services necessary for the maintenance of the Participant's home performed in and about the home and which are attributable in part to the care of a Qualifying Individual, as more fully defined by applicable law.

(vi) "Qualifying Individual" means:

(A) a Participant's dependent who is a "qualifying child" (within the meaning of Code Section 152) under the age of 13 or, for the 2020 Plan Year or the 2021 Plan Year (with respect to unused 2020 Dependent Care FSA amounts) under the age of 14, or

(B) a dependent (within the meaning of Code Section 152, as it applies for purposes of a dependent care assistance program described in Code Section 129) or Spouse of the Participant who is physically or mentally incapable of self-care and who has the same principal place of abode as the taxpayer for more than one-half of the applicable tax year of the Participant. An individual is physically or mentally incapable of self-care if, because of a physical or mental defect, he or she is incapable of caring for his or her own hygiene or nutritional needs, or requires full-time attention of another person for his or her own safety or the safety of others. The inability of an individual to engage in any substantial gainful activity or to perform the normal household functions of a homemaker or to care for minor children does not by itself establish that the individual is physically or mentally incapable of self-care.

Notwithstanding any provision of this Plan to the contrary, "Qualifying Individual" at all times shall be interpreted to have the same meaning as that term has under Code Section 21(b)(1), as it applies for purposes of a dependent care assistance program described in Code Section 129.

APPENDIX I

HOUSE STAFF SUPPLEMENTAL FUND
(for House Staff Medical Plan Participants Only)

1.1 Establishment of House Staff Supplemental Fund. Each eligible Employee who is enrolled in medical coverage under the Plan is eligible for benefits under the House Staff Supplemental Fund Component Plan (Supplemental Fund) and is entitled to receive cash reimbursement from the Employer for certain health-related expenses (described below) incurred during a Plan Year in an amount not to exceed the amount credited to the Participant's Supplemental Fund Account. An eligible Participant will receive credits to his or her Supplemental Fund Account at such times and in such amounts as described below.

(i) The Supplemental Fund is intended to qualify as an employer-provided health reimbursement arrangement, as described in IRS Notice 2002-45. Notwithstanding anything in the Plan to the contrary, the Supplemental Fund is not intended to be a Code Section 125 "cafeteria plan," and any reimbursements paid under the Supplemental Fund are provided solely by the Employer and not pursuant to any salary reduction election. Any provision of this Plan (or of any other document that controls the terms of the Supplemental Fund) that would cause the Supplemental Fund to fail to qualify as an employer-provided health reimbursement arrangement described in IRS Notice 2002-45 or that would cause the Supplemental Fund to violate any applicable nondiscrimination requirements or other applicable legal requirements, will be ineffective.

(ii) The amount to be credited for each Plan Year to the Supplemental Fund Account of each eligible Participant for a Plan Year will be announced by the Employer before the start of each Plan Year and generally will vary depending on whether the eligible Participant has elected coverage for any eligible Dependents.

(iii) The amount (as described above) to be credited to an eligible Participant's Supplemental Fund Account for a Plan Year will be credited in its entirety as of the first day of the Plan Year, or, if later, the date the Participant becomes an eligible Participant. In no event will amounts be available for reimbursement before they are credited to the Participant's Supplemental Fund Account.

(iv) Payments under the Supplemental Fund will be made only after the Participant has paid a designated minimum amount of out-of-pocket expenses under the medical Component Plan. For each Plan Year, the designated minimum amount that must be paid before any Supplemental Fund payments are available is $1,000 for a Participant with individual coverage under the Plan and $3,000 for a Participant with coverage for more than one person. The out-of-pocket limit for medical coverage is $3,000 per individual or $9,000 per family. This means that the Supplemental Fund will reimburse the eligible Employee up to $2,000 for an individual or $6,000 for a family per plan year. This minimum amount is subject to change as announced by the Employer before the start of the applicable Plan Year or at other times.

(v) Payments under the Supplemental Fund will be made as a

reimbursement for health-related expenses incurred during the Plan Year and after the Participant's Participation Date by the Participant or his or her Spouse (for purposes of federal law) or dependents that:

(A) Are not covered, paid or reimbursed under any other health plan coverage;

(B) Meet the criteria for medical expenses under Code Section 213(d) (other than long term care expenses);

(C) Are not taken as a deduction from income on the Participant's federal income tax return in any tax year; and

(D) Qualify as expenses that apply to the Participant's deductible, copayments or other out-of-pocket expenses under the Employer's medical plan (as determined by the Administrator)".

In no event will any Participant or former Participant have the right to receive cash or any other taxable or nontaxable benefit from the Account other than the reimbursement of medical care expenses, as defined in Code Section 213.

(vi) Notwithstanding any other provision of the Plan (or other document that controls the terms of a Participant's health care flexible spending account or the Supplemental Fund) that restricts a Participant from obtaining reimbursement from his or her health care flexible spending account or under the Supplemental Fund for expenses that are covered, paid or reimbursed under any other health plan coverage, if, absent such restriction, an expense is reimbursable under both the health care flexible spending account and the Supplemental Fund, the Participant may be reimbursed for such expense from the Supplemental Fund only if the amount available under the Participant's health care flexible spending account has been exhausted. In no event may a Participant receive reimbursement for the same expense from a health care flexible spending account and under the Supplemental Fund.

(vii) For purposes of this subsection, "dependent" means any person who is covered as a Dependent under the Participant's medical coverage.

(viii) Any amounts credited to a Participant's Supplemental Fund Account for a Plan Year after the deadline for reimbursement requests for the applicable Plan Year and after all properly submitted reimbursement requests have been paid will be forfeited.

Additionally, amounts credited to a Participant's Supplemental Fund Account upon the termination of the Participant's employment may be used for reimbursement following such termination of employment, but only for eligible expenses which were incurred prior to the Participant's termination of employment. Any amounts credited to a Participant's Supplemental Fund Account at the end of a Plan Year against which liabilities have not been accrued during the Plan Year which are not carried forward pursuant to the preceding shall be forfeited upon the earlier of (1) the end of the Plan Year or (2) the date the Participant ceases to be

a Participant in the Supplemental Fund.

(ix) Any Participant who wishes to receive a reimbursement from his or her Supplemental Fund Account must submit to the Administrator a request for reimbursement on a form provided by the Administrator, along with such evidence as the Administrator requires regarding the amount, nature and payment of such reimbursement. The Administrator may establish reasonable rules regarding the deadline for submitting reimbursement requests and minimum amount of eligible expenses that must be submitted for reimbursement to be made under the Plan. All claims must be submitted to the Administrator no later than December 31st following the end of the Plan Year.

1.2 Termination of Participation. Any Participant who ceases to participate in a medical benefit option under the Plan will simultaneously cease to be a Participant in the Supplemental Fund.

APPENDIX J

SHORT TERM DISABILITY

ANY EVIDENCES OF COVERAGE, CERTIFICATES OF INSURANCE, PLAN DOCUMENTS, AND ANY SHORT TERM DISABILITY BENEFIT BOOKLET ARE INCORPORATED BY REFERENCE INTO THIS APPENDIX J.

APPENDIX K

CHILD CARE CENTERS

ANY EVIDENCES OF COVERAGE, CERTIFICATES OF INSURANCE, PLAN DOCUMENTS, AND ANY CHILD CARE CENTER BENEFIT BOOKLET ARE INCORPORATED BY REFERENCE INTO THIS APPENDIX K