

MIDDLEBURY
HEALTH REIMBURSEMENT ARRANGEMENT FOR CERTAIN FORMER
MIDDLEBURY EMPLOYEES

PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION

Effective January 1, 2019

MIDDLEBURY
 HEALTH REIMBURSEMENT ARRANGEMENT FOR CERTAIN FORMER MIDDLEBURY
 EMPLOYEES
 SUMMARY PLAN DESCRIPTION

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INTRODUCTION

Middlebury College (“Middlebury”) established the Middlebury Health Reimbursement Arrangement for Certain Former Middlebury Employees (the "Plan"), effective January 1, 2019.

This Plan is intended to be a health reimbursement arrangement (“HRA”) as defined under IRS Notice 2002-45 and health insurance premiums reimbursed under the Plan are intended to be eligible for exclusion from participants’ gross income under Section 106 of the Internal Revenue Code. This Plan covers only certain former employees of Middlebury; active employees are not eligible.

In order to ensure Middlebury has the flexibility to address changes that might be needed with respect to the Plan (whether as a result of legal changes, changes made by providers, or other changing circumstances), Middlebury reserves the right to modify or terminate the Plan at any time. If there is any inconsistency between any description of benefits provided to you and the terms of the Plan as set forth in this document, the terms of this document will control and Middlebury will have the discretionary authority to construe any ambiguous or uncertain provisions.

ELIGIBILITY FOR PARTICIPATION

Eligible Participant

You are an "Eligible Participant" if you are a former employee of Middlebury and are among a select group of individuals eligible for benefits under one of several separately administered special benefit programs.

There are two categories of Eligible Participants under the Plan: (1) “Pre-2019 Group” and (2) “Post-2018 Group.” As explained below, Plan benefits may differ depending upon whether you are in the Pre-2019 or the Post-2018 Group.

I. Pre-2019 Group

You are in the Pre-2019 Group and eligible for Plan benefits, if you satisfy one of the following eligibility requirements:

You are a Middlebury retiree and you received subsidized retiree health benefits (medical or dental) under the Middlebury Health and Welfare Benefits Plan (“Health and Welfare Benefits Plan”) prior to January 1, 2019 pursuant to one of the following retiree programs and you would have been eligible to continue to receive such benefits after January 1, 2019 had such retiree benefits not been eliminated from the Health and Welfare Benefits Plan:

- 1) Sick Leave Reserve or Faculty Leave Reserve Conversion Programs;
- 2) Disability Transition Benefit Program; and

- 3) Subsidized Retiree Health Coverage Program (made available to former employees and surviving spouses pursuant to Middlebury's former group health benefits plan for retirees).

OR

You are a former Middlebury employee and you received health benefits (medical or dental) under the Middlebury Health and Welfare Benefits Plan ("Health and Welfare Benefits Plan") prior to January 1, 2019:

- 4) Separation Agreement (made available to certain individuals who terminated employment prior to January 1, 2019 and executed a College-approved voluntary or involuntary separation agreement ("Separation Agreement") which includes post-2018 benefits under this Plan.

II. Post-2018 Group

You are in the Post-2018 Group and eligible for Plan benefits, if you satisfy one of the following eligibility requirements:

1) Sick Leave Reserve and Faculty Leave Reserve Conversion Programs

You are eligible for a Plan benefit pursuant to the Sick Leave Reserve or the Faculty Leave Reserve Conversion Programs (as applicable), if you terminate from employment on or after January 1, 2019 and you qualify as a Middlebury retiree:

- You were employed by Middlebury for ten consecutive years following the attainment of age forty-five in a benefits eligible position; or
- You were employed as a faculty employee, but resigned from a tenured position to take a part-time position, regardless of your age or years of service.

You are only eligible for a Plan benefit pursuant to the Sick Leave Reserve or Faculty Leave Reserve Conversion Programs (as applicable) if you have accumulated, unused Sick Leave Reserve or Faculty Leave Reserve hours credited to your leave account at the time of your retirement. The amount of your accumulated leave reserve is determined pursuant to separately administered policies maintained by Middlebury. Please contact the Office of Human Resources if you have questions regarding your accumulated Sick Leave Reserve or Faculty Leave Reserve hours.

2) Disability Transition Program

You are eligible for a Plan benefit pursuant to the Disability Transition Program if you become disabled and (i) your disability is a qualifying disability that entitles you to disability benefits pursuant to the terms of Middlebury's short-term disability plan ("Short-Term Disability Plan"), long term disability plan ("Long-term Disability Plan"), or Worker's Compensation

benefits, as in effect at the time of your disability (collectively, the “Disability Programs”) and (ii) your employment with Middlebury ended on or after January 1, 2019 as a result of said disability. You are eligible for a monthly Plan contribution for the period during which you remain disabled pursuant to the terms of the above mentioned benefit plans, up to a specified maximum number of months (see page 7 for details).

3) Incentive Separation Program or Agreement

If you terminate from employment on or after January 1, 2019 as a result of participation in a College-approved retirement or voluntary or involuntary separation incentive program or agreement offered by Middlebury (“Separation Program” or “Agreement”) which includes benefits under this Plan, you will be eligible for a Plan benefit subject to the terms and conditions of the applicable Separation Program or Agreement. The eligibility requirements of the Separation Program or Agreement are incorporated by reference into this Plan.

Date of Participation

You will become an Eligible Participant on the date Middlebury first establishes an HRA account in your name and funds the account (“HRA Account”). Your HRA Account will be funded as soon as administratively feasible following your retirement or other qualifying termination from employment.

Cessation of Participation

You will cease being an Eligible Participant in the Plan on the earlier of (i) the date you are rehired by Middlebury as an active employee; (ii) the date you no longer satisfy the Plan’s eligibility requirements; (iii) your date of death, subject to the provisions of the Plan that allow continued reimbursements by other Covered Persons surviving your death (see page 10 for details); (iv) the effective date of any amendment terminating your eligibility under the Plan; or (v) the date the Plan is terminated.

Rehired Participants

If you are an Eligible Participant and are rehired by Middlebury, your HRA Account will be suspended for your period of employment with Middlebury (“Suspension Period”). During the Suspension Period, contributions to your HRA Account (if any) cease and you will not be able to submit Eligible Expenses for reimbursement during the Suspension Period. You will be eligible to recommence participation in the Plan once your employment with Middlebury ends and the Suspension Period expires (Eligible Expenses incurred during the Suspension Period may not be reimbursed following the end of the Suspension Period). Please note the Suspension Period shall apply regardless of your position with Middlebury upon rehire and regardless of your scheduled hours (i.e., the Suspension Period will apply even if you are rehired by Middlebury into a non-benefits-eligible part-time or temporary position).

HEALTH REIMBURSEMENT BENEFITS

Health Reimbursement Account

When you become eligible to participate in the Plan, Middlebury will establish an HRA Account in your name. You will be entitled to receive reimbursement from this account for Eligible Expenses incurred by you, your spouse and dependents, if any (collectively, referred to as “Covered Persons”).

Your spouse is the individual who is treated as your spouse for federal tax purposes.

Your dependent is generally someone who you may claim as a dependent on your federal tax return and also includes a child who is under the age of 27 through the end of the tax year. This definition includes your tax dependent, as defined in Internal Revenue Code (“Code”) Section 105(b) and any individual who is your child as defined by Code Section 152(f)(1) and who has not attained age 27 by the end of the tax year; provided, however, that any child to whom Code Section 152(e) applies (regarding a child of divorced parents, etc. where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child’s support for the calendar year) is treated as a dependent of both parents.

In addition, the Plan will allow reimbursement of eligible medical expenses for your child (as defined by applicable state law) in accordance with a Qualified Medical Child Support Order (“QMCSO”) to the extent the QMCSO does not require coverage not otherwise offered under the Plan. The Plan Administrator will make a determination as to whether the order is a QMCSO in accordance with the Plan’s QMCSO procedures. The Plan Administrator will notify both you and the affected child once a determination has been made.

Health Reimbursement Arrangement Benefits

The Plan will reimburse Eligible Participants for Eligible Expenses up to the unused amount in the Eligible Participant’s HRA Account. The amount, and timing, that will be credited to your HRA Account will depend upon your eligibility category, as described below:

I. Pre-2019 Group

Sick Leave Reserve and Faculty Leave Reserve Conversion Program Participants

If you are an Eligible Participant in this category and are eligible for a benefit pursuant to either the Sick Leave Reserve or the Faculty Leave Reserve Conversion Programs, your Plan benefit will be equal to the number of College-paid months of health coverage documented in your retirement letter (the terms of which are hereby incorporated by reference) remaining available on or after January 1, 2019, multiplied by the monthly premium cost of the health benefits (medical and dental, as applicable) for the coverage tier (e.g., single, two person, family) you were enrolled in on December 31, 2018 under the Health and Welfare Benefits Plan.

Example: Your retirement letter from Middlebury stated you are eligible for Middlebury-paid retiree health benefits through June 30, 2019. As of December 31, 2018, you were enrolled in the retiree age 65 and over medical and dental benefits under the Health and Welfare Benefits Plan with single coverage. The 2018 monthly premiums for retiree medical and dental were: medical - \$557.00; dental - \$67.98. Your HRA Account will be credited with \$3,749.88 (6 months x \$624.98 = \$3,749.88).

Group Disability Transition Program Participants

If you are an Eligible Participant in this category, your monthly Plan benefit will be equal to the number of College-paid months of health coverage documented in your disability retirement letter (the terms of which are hereby incorporated by reference) remaining available on or after January 1, 2019, multiplied by the monthly premium cost of the single retiree under age 65 health benefits (medical and dental, as applicable) you were enrolled in on December 31, 2018 under the Health and Welfare Benefits Plan.

Example: You incurred a qualifying disability and as a result ended employment and began Disability Retirement on October 1, 2016, and you otherwise satisfy the eligibility requirements for a benefit under the Plan. At the time of your disability, you had completed ten (10) years of service with Middlebury and therefore were eligible for twenty-nine (29) months of College-paid benefits. As of December 31, 2018 the premium cost for single under age 65 medical coverage under the Health and Welfare Benefits Plan is \$1,071.39 and retiree dental is \$67.98. Your Plan benefit is equal to \$1,139.37 per month, paid in monthly installments until the earlier of (1) the expiration of 2 months (the number of post-December 2018 benefits you are due), or (2) the date that you are no longer considered disabled, as determined pursuant to the terms of the applicable Disability Program.

Subsidized Retiree Program

If you are an Eligible Participant in this category (or a surviving spouse of an Eligible Participant in this category)) who received subsidized retiree health coverage made available to grandfathered former employees and surviving spouses pursuant to Middlebury's former group health benefits plan for retirees, your monthly Plan benefit will be equal the excess, if any, between the amount of the monthly premium for the retiree medical only insurance coverage you elect post 2018 and the amount you paid for the retiree medical coverage you received under the Health and Welfare Benefits Plan for the 2018 plan year, up to a maximum of the amount that your medical coverage was subsidized per month by Middlebury with respect to your Health and Welfare Benefit Plan coverage during the 2018 plan year.

Example: In 2018, the total cost of single retiree over age 65 coverage was \$557 per month under the Middlebury Health and Welfare Benefits Plan. You were eligible for a subsidized premium and paid \$400 for month, with Middlebury subsidizing \$157 of the premium. In 2019, you obtain medical coverage from another source eligible for reimbursement under this Plan. The premium for such health coverage is \$500 per

month. You are entitled to a monthly Plan benefit of \$100. If in 2019 you instead obtained coverage that cost \$600 per month, you would be eligible for a monthly plan benefit of \$157 per month (the amount of your Middlebury subsidy as of December 31, 2018). Please note these figures are hypothetical premium amounts. Your actual HRA benefit will be based on your own pre-2019 subsidy and post-2019 premium amounts.

In order to be eligible for HRA benefits under this plan provision, otherwise eligible retirees must provide Middlebury College's Human Resources Department, by December 31st of each year, proof of the medical plan, including cost, in which the retiree and/or retiree spouse has enrolled for the subsequent year. Failure to provide timely documentation will result in loss of benefits under this provision. Plan confirmation should be sent to: Middlebury College Human Resources, 152 Maple Street, Middlebury, VT 05753.

Separation Agreement

If you are an Eligible Participant in this category, your Plan benefit will be the amount that is specified in the applicable Separation Agreement.

II. Post-2018 Group

Sick Leave Reserve and Faculty Leave Reserve Conversion Program Participants

If you are an Eligible Participant in this category and are eligible for a benefit pursuant to either the Sick Leave Reserve or the Faculty Leave Reserve Conversion Programs, your Plan benefit will be determined as follows:

- **“Total Monthly Premium”** At the beginning of each calendar year, the monthly premium cost for *single* coverage for the medical, dental and vision benefits offered to active employees under the Health and Welfare Benefits Plan during that plan year will be added together to determine a total monthly premium (“Total Monthly Premium”).
- **“HRA Benefit Multiplier”** At the beginning of each calendar year, the HRA Benefit Multiplier for that year will be determined by dividing the Total Monthly Premium by 173.33 (the monthly work hours equivalent used by this plan).

In the year in which you retire from employment:

- Your accrued unused Sick Leave Reserve or Faculty Leave Reserve balance (as applicable) at the time of your retirement will be multiplied by the HRA Benefit Multiplier.
- The resulting number will be converted into a dollar equivalent contribution to the HRA.

Example: In 2019, the single premium costs for the medical, dental and vision benefits

offered under the Health and Welfare Benefits Plan for active employees are as follows: Medical - \$804.27; Dental-\$54.72; Vision - \$5.65. ** The Total Monthly Premium is \$864.64 and therefore the 2019 HRA Benefit Multiplier is 4.99 ($\$864.64/173.33 = 4.99$).

You retire on June 1, 2019 with 1,200 accrued and unused Sick Leave Reserve Hours. At the time of your retirement, your HRA benefit is \$5,988 ($\4.99 (the 2019 Benefit Multiplier) x 1,200 (your SLR balance)).

** Please note these are hypothetical premium amounts. Your actual HRA benefit will be based on the premium amounts in effect during the year of your retirement.

Group Disability Transition Program Participants

If you are an Eligible Participant in this category, your monthly Plan benefit will equal the monthly premium cost for single medical, dental and/or vision coverage under the Health and Welfare Benefits Plan at the time you terminate from employment as a result of your qualifying disability, only to the extent that you were enrolled in such benefits as of the date of your qualifying disability. Your monthly benefit will continue to be credited to your HRA Account for the number of months listed in the chart below, so long as you remain disabled (as determined pursuant to the applicable Disability Program).

Years of Service	Months of Coverage
<1	0
1	2
2	5
3	8
4	11
5	14
6	17
7	20
8	23
9	26
10+	29

*Example: You incur a qualifying disability on October 1, 2019 and otherwise satisfy the eligibility requirements for a benefit under the Plan. At the time of your disability, you have completed five (5) years of service with Middlebury and were enrolled in family medical coverage only (no dental or vision). In 2019, the premium cost for single medical coverage under the Health and Welfare Benefits Plan is \$804.27. ** Your Plan benefit is equal to \$804.27 per month, paid in monthly installments until the earlier of (1) the expiration of 14 months, or (2) the date that you are no longer considered disabled, as determined pursuant to the terms of the applicable Disability Program.*

** Please note this figure is a hypothetical premium amount. Your actual HRA benefit

will be based on the premium amount in effect during the year of your disability termination and the plans in which you were enrolled.

Separation Program/Agreement

If you are an Eligible Participant in this category, your Plan benefit will be the amount that is specified in the applicable Separation Program document or Agreement.

Timing of Contribution

If you are an Eligible Participant due a benefit under Middlebury's Sick Leave Reserve or Faculty Leave Reserve Programs, or any approved Separation Program/Agreement, your benefit will be paid in a lump sum contribution at the time your HRA Account is established and you will have immediate access up to the full account balance.

If you are eligible for a benefit under Middlebury's Disability Transition Program or Subsidized Retiree Program (former retiree or surviving spouse), your contribution will be funded on a month-to-month basis. That is, one twelfth of the annual limit specified in your program will be credited to your account at the beginning of each calendar month during the Plan Year.

Any amounts remaining in your account at the end of the Plan Year will be carried over to the immediately-following Plan Year.

HRA Accounts

An HRA Account is merely a bookkeeping account in Middlebury's records; it is not funded (i.e., the HRA contributions are merely notation credits to your HRA Account) and does not bear interest or accrue earnings of any kind. All reimbursements under the Plan are paid entirely from Middlebury's general assets.

HRA contributions will be credited in the amount specified in this Section and will be reduced from time to time by the amount of any Eligible Expenses for which a Covered Person is reimbursed under the Plan. At any time, an Eligible Participant may receive reimbursement for Eligible Expenses up to the amount in his or her HRA Account. Note that the law does not permit Eligible Participants to make any contributions to their HRA Accounts.

Eligible Expenses

During the time you are eligible to participate in the Plan, the Plan will reimburse insurance premium costs for medical, dental and/or vision insurance coverage purchased by Covered Persons that is eligible for reimbursement under Section 213(d)(1)(D) of the Code. No other expense is eligible to be reimbursed under the Plan, regardless of whether such expense is considered an eligible medical expense under Section 213(d) of the Code.

You will not be reimbursed for any expenses that are (i) incurred before or after you are eligible to participate in the Plan, (ii) attributable to a tax deduction you take, or (iii) covered, paid or reimbursed from any other source.

CLAIMS

Deadlines

You must submit claims for reimbursement by 90 days after the end of the plan year in which they were incurred, that is, by March 31st of the year following the year in which the service was incurred.

Documentation of Claims

Any claim for benefits must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merits of the claim. The Plan Administrator may request any additional information necessary to evaluate the claim.

Method and Timing of Payment

To the extent that the Plan Administrator (or its designee) approves a claim, the Plan Administrator (or its designee) may either (i) reimburse you, or (ii) pay the insurance company directly. The Plan Administrator will pay approved claims on a weekly basis. The Plan Administrator may provide that payments/reimbursements of less than a certain amount will be carried forward and aggregated with future claims until the reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments/reimbursements outstanding at the end of the Plan Year will be reimbursed without regard to the minimum payment amount.

Where to Submit Claims

All claims must be submitted to Business Plans, Inc./myCafeteriaPlan at 432 East Pearl St, Miamisburg, OH 45342 or faxed to (937) 865-6502. Mobile and web claim submission options are also available. For information or assistance contact customer service at (800) 865-6543.

Refunds/Indemnification

You must immediately repay any excess payments/reimbursements. You must reimburse Middlebury for any liability Middlebury may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may offset other benefits payable under this Plan.

Death of Eligible Participant

If you die, your spouse will automatically be named as the designated account holder with respect to your HRA Account. If you do not have a surviving spouse upon your death, the Plan Administrator may designate one of your dependents as the designated account holder. After your death, your spouse and dependents may continue to submit claims for Eligible Expenses as long as they remain eligible to participate in the Plan as a Covered Person. Upon the death of the last eligible Covered Person with respect to an HRA Account, the deceased Covered Person's estate or representatives may submit claims for Eligible Expenses incurred by the Covered Person. Such claims must be submitted within 90 days following the end of the Plan Year in which the Covered Person died. Any amounts remaining after 90 days following the end of the Plan Year in which the last living Covered Person eligible to receive reimbursements from an HRA Account has died will be forfeited. Unused amounts may not be cashed out.

Claim Procedures for Health Benefits

Application for Benefits. You or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim must be in writing and must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (4) an explanation of the steps that the Claimant must take if he or she wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA, and (5): (A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or (B) if the adverse

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

Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 180th day after he receives the Plan Administrator's notice that the claim has been wholly or partially denied. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator shall:

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

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

(3) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(4) Provide that the health care professional engaged for purposes of a consultation under Subsection (2) shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination. The Claimant shall lose the right to appeal if the appeal is not timely made.

Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial with a discussion of the decision, (2) the pertinent Plan provisions on which the denial is based, (3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable

access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (4) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator shall be binding upon all parties.

CONTINUATION RIGHTS

COBRA

Under a federal law called “COBRA,” your spouse, former spouse, child or other tax dependent (a “COBRA Eligible Individual”) may be able to elect to continue coverage under the Plan for a limited time after the date they would otherwise lose coverage because of a divorce or legal separation from the Participant, or occurrence of another event that would cause a Participant’s child or other tax dependent to cease to be eligible for reimbursements from the Participant’s HRA Account (for example, a child’s attainment of age 26; if the child is not a tax dependent). These are called “qualifying events.”

Note that COBRA Eligible Individuals are required to notify the Plan Administrator in writing of a divorce, legal separation, 26th birthday, or loss of tax-dependent status within 60 days of the event or they will lose the right to continue coverage under the Plan.

If a COBRA Eligible Individual elects to continue coverage, he or she is entitled to the level of coverage under the Plan in effect immediately preceding the qualifying event and will be referred to as a “qualified beneficiary.”

In order to continue coverage, the qualified beneficiary must pay a monthly premium of up to 102% of the cost of the coverage, as determined by the Plan Administrator. The Plan Administrator will notify qualified beneficiaries of the applicable premium at the time of a qualifying event. Coverage may continue for up to 36 months following the qualifying event, but will end earlier upon the occurrence of any of the following events:

- The date the qualified beneficiary’s HRA Account is exhausted;
- The date the qualified beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage;
- The date any required monthly premium is not paid when due or during the applicable grace period; or
- The date Middlebury ceases to provide any group health plan.

YOUR RIGHTS UNDER ERISA

As a participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). This federal law provides that you have the right to:

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration if a Form 5500 is required to be filed by the plan.

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

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

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

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

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may

order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

MISCELLANEOUS

Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO). You may obtain a copy of the QMCSO procedures from the Plan Administrator, free of charge.

Alienation and Assignment

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan.

Amendment and Termination

Middlebury may amend, terminate or merge the Plan at any time. Additional information regarding Middlebury's amendment and termination rights is set forth in the Plan Information Appendix.

Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding. Additional information regarding the Plan Administrator's discretion is set forth in the Plan Information Appendix.

Taxation

Middlebury intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, Middlebury does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to

determine the tax consequences of your participation in this Plan.

Privacy

The Plan is required under federal law to take sufficient steps to protect any individually identifiable health information to the extent that such information must be kept confidential. The Plan Administrator will provide you with more information about the Plan's privacy practices. Additional information regarding the Plan's privacy requirements is set forth in the Plan Information Appendix.

Minor or Legally Incompetent Payee

If a distribution is to be made to an individual who is either a minor or legally incompetent, the Plan Administrator may direct that such distribution be paid to the legal guardian. If a distribution is to be made to a minor and there is no legal guardian, payment may be made to a parent of such minor or a responsible adult with whom the minor maintains his or her residence, or to the custodian for such minor under the Uniform Transfer to Minors Act, if such is permitted by the laws of the state in which the minor resides. Such payment shall fully discharge the Plan Administrator and Middlebury from further liability regarding such benefit.

Missing Payee

If the Plan Administrator is unable to make payment to any Covered Person or other person to whom payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Covered Persons or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited one year after the date any such payment first became due.

ADMINISTRATIVE INFORMATION

Plan Name and Effective Date

The full name of the Plan is the Middlebury Health Reimbursement Arrangement for Certain Former Middlebury Employees. The terms of this document are effective January 1, 2019.

The Plan Sponsor and Plan Administrator

The President and Fellows of Middlebury College
152 Maple Street
Middlebury, VT 05753

Telephone 802-443-5755

College Identification Number 03-0179298

Type of Plan

The Plan is a welfare benefit plan.

Plan Number

The number assigned to the Plan is 503.

Agent For Service of Legal Process

The Plan's designated agent for service of legal process is the General Counsel of the President and Fellows of Middlebury College. Any legal papers should be delivered to him or her at the address listed above. However, service may also be made upon the Plan Administrator.

Plan Year

Middlebury's fiscal year ends on June 30 and the plan year ends on December 31.

Funding

All of the amounts payable under this Plan shall be paid from the general assets of Middlebury. Nothing in this document will be construed to require Middlebury to maintain any fund or to segregate any amount for the benefit of any participant, and no participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of Middlebury from which any payment under the Plan may be made. There is no trust or other fund from which benefits are paid.

Plan Administration

The Plan is administered by a third-party administrator.

PLAN INFORMATION APPENDIX

ARTICLE I

ADMINISTRATION OF PLAN

1.1 **Plan Administrator.** The administration of the Plan shall be under the supervision of the Plan Administrator. It shall be a principal duty of the Plan Administrator to see that the Plan is carried out in accordance with its terms. The Plan Administrator will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator's powers will include, but will not be limited to, the following authority, in addition to all other powers provided by this Plan:

- (a) to make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;
- (b) with respect to Plan administration, to interpret and apply the Plan and any related documents;
- (c) to allocate and delegate its responsibilities under the Plan, including, but not limited to, appointment of a claims administrator with respect to any benefit under the Plan;
- (d) to establish procedures for the determination of the qualified status of medical child support orders; to administer the provision of benefits under qualified medical child support orders; to effect direct payment of benefits to alternate recipients, their custodial parents or legal guardians, as applicable; and otherwise to comply with the provisions of Section 609 (or such successor Section) of ERISA; and
- (e) to establish procedures and to interpret and administer the Plan in accordance with COBRA and other requirements of law.

1.2 **Advisors; Reliance on Tables, Etc.** The Plan Administrator may employ such actuaries, attorneys, accountants, employee benefit consultants, and other specialists (collectively, "Advisors") as may be required to assist in fulfilling its responsibilities under the Plan. The Plan Administrator will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports which are furnished by or in accordance with the instructions of an Advisor.

1.3 **Fiscal Records.** The fiscal records of the Plan are to be maintained on the basis of the Plan Year.

1.4 **Administrative Expenses.** All expenses incurred by the Plan in the administration of the Plan, including legal and other fees and expenses, will be paid by the Plan to the extent permitted by ERISA and not otherwise paid by Middlebury.

1.5 **Indemnity by Middlebury.** In the event and to the extent not insured against by any insurance company, Middlebury shall indemnify and hold harmless any of its employees acting as Plan Administrator from any and all claims, demands, suits, or proceedings in connection with the Plan that may be brought by the Participants or their beneficiaries or legal representatives, or by any other person, corporation, entity, government, or agency thereof; provided, however, that such indemnification shall not apply to any such person for such person's acts of willful or grossly negligent misconduct in connection with the Plan, or for breaches of such person's fiduciary obligations or duties, as described under ERISA.

1.6 **Authority to Interpret and Apply the Plan and Related Documents.** With respect to claims administration and all other aspects of Plan administration, Middlebury (and its designee(s)), the Plan Administrator (and its designee(s)) and the claims administrator, to the full extent permitted by law, shall have the authority and discretion to interpret and apply the Plan and any related documents and to decide all questions concerning the Plan and its application, including, but not limited to:

- (a) determining questions of fact and/or law;
- (b) deciding the eligibility of any person to be covered under the Plan;
- (c) determining the amount of benefits (if any) a person is entitled to under the Plan;
- (d) exercising discretion to construe any uncertain or disputed term or provision in the Plan; and
- (e) reviewing any prior benefit claim determination under the Plan.

All such interpretations and decisions shall:

- (i) be final and conclusive on all persons, including those persons claiming benefits under the Plan; and
- (ii) be given deference in all courts of law, to the greatest extent allowed by applicable law.

ARTICLE II

AMENDMENT OR TERMINATION OF PLAN

2.1 **No Contractual or Vesting Right to Benefits.** Notwithstanding any other provision of the Plan to the contrary, no Covered Person has any contractual or other right to continuation of this Plan, any Plan benefits, or Plan coverage in the future. Middlebury makes no promise to continue Plan benefits in the future and rights to future benefits will never vest. In particular, retirement or other termination of employment does not in any manner confer upon any Covered Person or other interested party any right to Plan benefits that in any way interferes with Middlebury's right to amend or terminate the Plan at any time and from time to time.

2.2 **Right to Amend or Terminate.** Middlebury expressly reserves the right to amend or terminate this Plan, in whole or in part, at any time (and, in the case of amendments, from time to time) and for any reason. The types of amendments that may be made include, but are not limited to: (a) revising the eligibility requirements of the Plan; (b) reducing or eliminating any benefits offered under the Plan; and/or (c) curtailing or discontinuing College contributions to the Plan.

In addition, (a) the Finance Committee of the Board of Trustees shall be authorized to amend the Plan, pursuant to written resolutions, so long as the amendment shall have no material adverse impact on Middlebury, and (b) the President of Middlebury and the Vice President for Finance & Treasurer of Middlebury shall be authorized to amend the Plan, pursuant to joint written action, so long as the amendment shall have no material adverse impact on Middlebury or Participants.

Any amendment shall be binding upon each Covered Person.

2.3 **Additional Participating Colleges.** If any institution is now or becomes an affiliated entity, the Board of Trustees may include the entity in the membership of the Plan upon appropriate action by that entity necessary to adopt the Plan. In that event, if any persons become Eligible Participants as the result of merger or consolidation or as the result of acquisition of all or part of the assets or business of another institution, the Board of Trustees shall determine to what extent, if any, benefits shall be granted.

2.4 **Retroactive Amendments.** An amendment to this Plan may be made effective retroactively so long as it does not adversely affect the right of Participants to benefits under this Plan for claims incurred after the effective date of the amendment, but before the amendment is adopted.

2.5 **Procedures.** Amendment or termination of the Plan shall be effected by resolution(s) adopted by the Board of Trustees of Middlebury, or its authorized delegate.

2.6 **COBRA Rights.** Nothing in this Article shall be construed as interfering with an individual's COBRA continuation rights.

ARTICLE III

MISCELLANEOUS PROVISIONS

3.1 Information To Be Furnished.

(a) Participants shall provide Middlebury and Plan Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of Plan administration. If not so provided or signed, the Plan Administrator may deny benefits until the requested information, evidence, and/or documents is/are furnished.

(b) If a Covered Person (or any person or entity acting on behalf of a Covered Person) provides any false or misleading information to the Plan Administrator, the claims administrator, or Middlebury in connection with the Plan or any Plan benefit (e.g., in connection with eligibility for Plan coverage or a claim for benefits), the Plan Administrator, the Claims Administrator, or Middlebury shall have the discretionary authority, to the full extent permitted by law, to terminate the Covered Person's coverage and to recoup, offset or otherwise recover any overpayment or other benefit the Covered Person received as a result of such false or misleading information. Middlebury reserves the right to take any disciplinary action permitted by law as a result of such false or misleading information. In the case of fraud or an intentional misrepresentation of material fact, the Plan Administrator or its designee also reserves the right to terminate a Covered Person's coverage retroactively (e.g., retroactive to the individual's participation effective date), to the extent permitted by law, and to recoup, offset or otherwise recover any overpayment or other benefit the Covered Person received as a result of such fraudulent act or intentional misrepresentation.

(c) The Plan Administrator may release to, or obtain from, any person, company, or organization information reasonably necessary to carry out the purposes of this Plan, unless otherwise restricted by law.

3.2 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Covered Person or other person any legal or equitable right against Middlebury, the Plan Administrator or any designee, except as provided herein.

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

3.4 Governing Law. This Plan shall be construed, administered and enforced according to the laws of the State of Vermont, except to the extent preempted by Federal law.

3.5 Medicaid Requirements. Notwithstanding any other provision of the Plan to the contrary, benefits will be paid in accordance with any assignment of rights made by or on behalf of a Covered Person as required by a state plan for medical assistance approved under title XIX

of the Social Security Act (“Act”) pursuant to section 1912(a)(1)(A) of such Act (as in effect on August 10, 1993). The enrollment and payment of benefits of a Covered Person under the Plan will not be affected by the fact that such individual is eligible for or is provided medical assistance under a state plan for medical assistance approved under title XIX of the Act.

To the extent that payment has been made under a state plan for medical assistance approved under title XIX of the Act in any case in which the Plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under the Plan will be made in accordance with any state law which provides that the State has acquired the rights with respect to a Participant to such payment for such items or services.

3.6 **Headings.** The headings and sub-headings of this Plan have been inserted for convenience of reference and are to be ignored in any construction of the applicable provisions.

3.7 **Protective Clause.** Middlebury shall not be responsible for the validity of any third party administrator document issued in connection with the Plan or for the failure on the part of a third party administrator to make payments provided by such documents, or for the action of any person which may delay such payment(s) or render such document(s) null and void or unenforceable in whole or in part.

3.8 **Compliance with Section 609 of ERISA.** The Plan is to be interpreted and applied in accordance with all applicable legal rules. Notwithstanding any other Plan provisions, this specifically includes a requirement that the Plan be interpreted and applied in accordance with the provisions of Section 609 of ERISA regarding: (a) qualified medical child support order; (b) the rights of states with respect to Covered Persons who are eligible for Medicaid; and (c) the coverage of children who are adopted or placed for adoption, as applicable, under Section 609. The Board of Trustees and/or the Plan Administrator, or appointed delegates of either, shall have the authority to promulgate and implement procedures and take any other actions necessary to comply with Section 609 of ERISA.

3.9 **Excess Payments.** If the Plan Administrator determines that any Claimant has directly or indirectly received excess payments/reimbursements or has received payments/reimbursements that are taxable to the Claimant, the Plan Administrator shall notify the Claimant and the Claimant shall repay such excess amount (or at the option of the Plan Administrator, the Claimant shall repay the amount that should have been withheld or paid as payroll or withholding taxes) as soon as possible, but in no event later than 30 days after the date of notification. A claimant shall indemnify and reimburse Middlebury for any liability Middlebury may incur for making such payments, including but not limited to failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If the Claimant fails to timely repay an excess amount and/or make sufficient indemnification, the Plan Administrator may offset other benefits payable hereunder.

ARTICLE IV

HIPAA PRIVACY AND SECURITY COMPLIANCE

4.1 **Definitions.** For purposes of this Article V, the following terms have the following meanings:

(a) “Business Associate” means any outside vendor who performs a function or activity on behalf the Plan which involves the creation, use or disclosure of PHI, and includes any subcontractor to whom a Business Associate delegates its obligations.

(b) “Group Health Benefits” means the medical benefits, dental benefits, vision benefits and, if applicable, employee assistance program benefits offered under the Plan.

(c) “Individual” means the Participant or the Participant’s covered dependents enrolled in any of the Group Health Benefits under the Plan.

(d) “Notice of Privacy Practices” means a notice explaining the uses and disclosures of PHI that may be made by the Plan, the covered Individuals’ rights under the Plan with respect to PHI, and the Plan’s legal duties with respect to PHI.

(e) “Plan Administration Functions” means the administration functions performed by the Plan Sponsor on behalf of the Plan. Plan Administration Functions do not include functions performed by the Plan Sponsor in connection with any other benefit plan of the Plan Sponsor.

(f) “Protected Health Information (“PHI”)” means information about an Individual, including genetic information, (whether oral or recorded in any form or medium) that:

- (1) is created or received by the Plan or the Plan Sponsor;
- (2) relates to the past, present or future physical or mental health or condition of the Individual, the provision of health care to the Individual, or the past, present or future payment for the provision of health care to the Individual; and
- (3) identifies the Individual or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual.

PHI includes Protected Health Information that is transmitted by or maintained in electronic media.

(g) “Summary Health Information “means information summarizing the claims history, claims expenses, or types of claims experienced by an Individual, and from which the following information has been removed:

- (1) names;
- (2) any geographic information which is more specific than a five digit zip code;
- (3) all elements of dates relating to a covered Individual (e.g., birth date) or any medical treatment (e.g., admission date) except the

year; all ages for a covered Individual if the Individual is over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);

- (4) other identifying numbers, e-mail addresses, VIN, or serial numbers;
- (5) facial photographs or biometric identifiers (e.g., finger prints); and
- (6) any other unique identifying number, characteristic, or code.

4.2 **HIPAA Privacy Compliance**. The Plan’s HIPAA privacy compliance rules (“Privacy Rule”) are as follows:

(a) Permitted Use or Disclosure of PHI by Plan Sponsor. Any disclosure to and use by the Plan Sponsor of any PHI will be subject to and consistent with this Section.

- (1) The Plan and health insurance issuer, HMO, or Business Associate servicing the Plan may disclose PHI to the Plan Sponsor to permit the Plan Sponsor to carry out Plan Administration Functions, including but not limited to the following purposes:
 - (A) to provide and conduct Plan Administrative Functions related to payment and health care operations for and on behalf of the Plan;
 - (B) for auditing claims payments made by the Plan;
 - (C) to request proposals for services to be provided to or on behalf of the Plan; and
 - (D) to investigate fraud or other unlawful acts related to the Plan and committed or reasonably suspected of having been committed by a Plan participant.
- (2) The uses described above in (1) are permissible only if the Notice of Privacy Practices distributed to covered Individuals in accordance with the Privacy Rule states that PHI may be disclosed to the Plan Sponsor.
- (3) The Plan or a health insurance issuer or HMO may disclose to the Plan Sponsor information regarding whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(b) Restrictions on Plan Sponsor’s Use and Disclosure of PHI.

- (1) The Plan Sponsor will not use or further disclose PHI, except as permitted or required by the Plan or as required by law.

- (2) The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides PHI agrees to the restrictions and conditions of this Section.
 - (3) The Plan Sponsor will not, and will not permit a health insurance issuer or HMO to, use or disclose PHI for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
 - (4) The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures allowed under this Section promptly upon learning of such inconsistent use or disclosure.
 - (5) The Plan Sponsor will make a covered Individual's PHI available to the covered Individual in accordance with the Privacy Rule.
 - (6) The Plan Sponsor will make PHI available for amendment and will, upon notice, amend PHI in accordance with the Privacy Rule.
 - (7) The Plan Sponsor will track certain PHI disclosures it makes so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with the Privacy Rule.
 - (8) The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of PHI received from the Plan to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with the Privacy Rule.
 - (9) The Plan Sponsor will, if feasible, return or destroy all PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control) received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Individual who is the subject of the PHI, when that PHI is no longer needed for the Plan Administration Functions for which the disclosure was made. If it is not feasible to return or destroy all such PHI, the Plan Sponsor will limit the use or disclosure of any PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.
 - (10) When using or disclosing PHI or when requesting PHI from another party, the Plan sponsor must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure, and limit any request for PHI to the minimum necessary to satisfy the purpose of the request.
 - (11) The Plan Sponsor will not use any genetic information for any underwriting purposes.
- (c) Adequate Separation between the Plan Sponsor and the Plan.
- (1) Only those employees of the Plan Sponsor, as outlined in the Plan's HIPAA Policies and Procedures, may be given access to

PHI received from the Plan or a health insurance issuer, HMO or Business Associate servicing the Plan.

- (2) The members of the classes of employees identified in the Plan's HIPAA Policies and Procedures will have access to PHI only to perform the Plan Administration Functions that the Plan Sponsor provides for the Plan.
- (3) The Plan Sponsor will promptly report to the Plan any use or disclosure of PHI in breach, violation of, or noncompliance with, the provisions of this Section of the Plan, as required under this Section, and will cooperate with the Plan to correct the breach, violation or noncompliance, will impose appropriate disciplinary action or sanctions, including termination of employment, on each employee who is responsible for the breach, violation or noncompliance, and will mitigate any deleterious effect of the breach, violation or noncompliance on any Individual covered under the Plan, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance. Regardless of whether a person is disciplined or terminated pursuant to this section, the Plan reserves the right to direct that the Plan Sponsor, and upon receipt of such direction the Plan Sponsor shall, modify or revoke any person's access to or use of PHI.

(d) Purpose of Disclosure of Summary Health Information to Plan Sponsor.

- (1) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan.
- (2) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

(e) Plan Sponsor Certification. The Plan Sponsor will provide the Plan with a certification stating that the Plan has been amended to incorporate the terms of this Article and that the Plan Sponsor agrees to abide by these terms. The Plan Sponsor will also provide the certification upon request to its health insurance issuers, HMOs and Business Associates of the Plan.

(f) Rights of Individuals.

- (1) Notice of Privacy Practices. The Plan Sponsor will provide a Notice of Privacy Practices to the Participant in accordance with HIPAA.
- (2) Right to Request Restrictions. Each Individual has the right to request that the Plan restrict its uses and disclosures of the Individual's PHI.

- (3) Right to Access. Each Individual has the right to obtain and inspect its PHI held by the Plan.
- (4) Right to Amend. Each Individual has the right to ask the Plan to amend its PHI.
- (5) Right to an Accounting. Each Individual has the right to request an accounting of disclosures of PHI made by the Plan for purposes other than treatment, payment or health care operations.

4.3 **HIPAA Security Compliance.** To ensure the Plan's compliance with HIPAA's privacy compliance rules ("Security Rule"), the Plan Sponsor will:

- (a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- (b) Ensure that the adequate separation required by the HIPAA Security Rule is supported by reasonable and appropriate security measures;
- (c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- (d) Report to the Plan any security incident of which it becomes aware.