

**ST. JOHN'S UNIVERSITY
WELFARE BENEFIT PLAN**

**Amendment and Restatement
Effective January 1, 2014**

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ARTICLE I
ESTABLISHMENT AND INTERPRETATION OF THE PLAN

Section 1.1 The Plan. Effective January 1, 2014, St. John's University (hereinafter the "Employer") amends and restates the St. John's University Welfare Benefit Plan (the "Plan").

Section 1.2 Purpose and Intent. The purpose of the Plan is to enable eligible employees to obtain health and welfare benefit coverage (the "Benefits") for themselves, their spouses and their eligible dependent children, and to provide them the ability to pay any portion of a benefit on a pre-tax basis, where applicable. Notwithstanding the number and types of benefits incorporated hereunder, the Plan is, and shall be treated as a wrapped document representing one single health and welfare plan for purposes of the reporting and disclosure requirements to the extent permitted under ERISA. The Plan is intended to meet all applicable requirements of the Internal Revenue Code and ERISA, as well as rulings and regulations promulgated thereunder.

Section 1.3 Definitions. The following terms shall have the meanings set forth below:

- (a) "Beneficiary" means an individual(s) designated by the Participant, or by the terms of the applicable Welfare Program, who is or may become entitled to a benefit thereunder.
- (b) "Claims Administrator" means a third party retained by the Plan to make determinations on claims for benefits under the Plan. For Welfare Programs which are fully-insured, the Claims Administrator is the insurance carrier.
- (c) "Code" means the Internal Revenue Code of 1986, as amended.
- (d) "Committee" means the Executive Director, Compensation and Employee Benefits of the Employer, or such other individual(s) as may be appointed by the Employer to supervise the administration of the Plan in accordance with Article IV.
- (e) "Dependent" means, with respect to a Welfare Program other than a plan established pursuant to Section 125 of the Code, the meaning given such term under the applicable Welfare Program to which it relates, as set forth in each Welfare Program's document, summary, certificate of coverage or booklet, or, to the extent not set forth in such document, in Appendix B.

With respect to a plan established pursuant to Section 125 of the Code, "Dependent" shall have the meaning given such term under Section 152 of the Code, without regard to Sections 152(b)(1) or (b)(2), or Section 152(d)(1)(B), and shall include the Employee's same or opposite sex spouse. Dependent shall also include an Employee's child (as defined in Section 152(f)(1) of the Code) through the end of the tax year in which the child attains age 26, without regard to the residency, support or other tests described in Section 152(c).

- (f) “Effective Date” means January 1, 2014, the effective date of this amended and restated Plan.
- (g) “Employee” means any person providing services to the Employer or a Participating Employer as a common-law employee or an employee who is on Leave of Absence. Individuals classified as independent contractors or leased employees, and any person whose employment is covered by the terms of a collective bargaining agreement (unless benefits were the subject of good-faith bargaining and the unit bargained into the Plan), shall not be Employees for purposes of this Plan. Individuals classified as independent contractors or leased employees shall not be “Employees” eligible to participate in the Plan even if this classification is incorrect and they are later determined by the Internal Revenue Service or some other court or agency of competent jurisdiction to in fact be common law employees of the Employer or considered employees for tax purposes.
- (h) “Employer” means St. John’s University and any successor or successors that continue to maintain the Plan. However, where appropriate, the term Employer shall also mean a Participating Employer that is the employer of a particular Participant.
- (i) “ERISA” means the Employee Retirement Income Security Act of 1974, as amended.
- (j) “Former Employee” means any person formerly employed as an Employee.
- (k) “Leave of Absence” means a personal leave, medical leave or military leave, as approved by the Employer.
- (l) “Participant” means any Employee or Former Employee who satisfies the requirements of Article II of the Plan, has chosen to participate in the Plan, and whose participation has not terminated in accordance with Section 2.4.
- (m) “Participant Contribution” means the pre-tax or after-tax contribution required to be paid by a Participant, if any, as determined under each Welfare Program. The term “Participant Contribution” includes contributions used for the provision of benefits under fully-insured insurance contracts or policies.
- (n) “Participating Employer” means any entity that is part of a group of entities that includes St. John’s University, and that constitutes: (A) a controlled group of corporations (as defined in section 414(b) of the Code); (B) a group of trades or businesses, whether or not incorporated, under common control (as defined in section 414(c) of the Code); or (C) an affiliated service group (with the meaning of section 414(m) of the Code), and that adopts the Plan. There are no Participating Employers at this time.
- (o) “Plan” means the St. John’s University Welfare Benefit Plan, which consists of this document and each Welfare Program’s policy, certificate of coverage, plan

document, summary document or booklet, incorporated hereunder by reference, as amended from time to time.

- (p) “Plan Administrator” means the Employer, unless another entity or person is appointed by the Employer to administer the Plan pursuant to Section 4.1.
- (q) “Plan Year” means the twelve (12) consecutive month period commencing each January 1 and ending on the last day of December.
- (r) “Welfare Program” means a written arrangement incorporated into this Plan that is offered by the Employer and/or a Participating Employer which provides any employee benefit that would be treated as an “employee welfare benefit plan” under Section 3(1) of ERISA if offered separately. Welfare Program also means any plan established pursuant to Section 125 of the Code, if incorporated herein on Appendix A. Each Welfare Program under the Plan is identified in Appendix A. The Employer may add or delete a Welfare Program from the Plan by amending Appendix A, without any need to otherwise amend the Plan. Amendment of Appendix A may be made by any authorized officer or representative of the Employer and shall not require approval by the Employer’s Board of Directors.

Section 1.4 Interpretation. In the event that the provisions of any Welfare Program conflict with or contradict the provisions of this document or any other Welfare Program, the Plan Administrator shall use its discretion to interpret the terms and purpose of the Plan so as to resolve any conflict or contradiction. However, the terms of this document may not enlarge the rights of a Participant, Dependent or Beneficiary to benefits available under any Welfare Program.

ARTICLE II
ELIGIBILITY AND PARTICIPATION

Section 2.1 Eligibility. An Employee or Former Employee shall be eligible to participate in the Plan only if and to the extent the Participant is eligible with respect to the particular benefit in question under a Welfare Program specified in Appendix A. The eligibility provisions for each Welfare Program currently offered under this Plan are specified in each Welfare Program's plan document, summary, booklet, or certificate or insurance, or, to the extent not so specified, are set forth in Appendix B. The Welfare Program(s) also designate those Dependents or Beneficiaries, if any, of a Participant eligible to receive benefits from the Plan and set forth the criteria for their becoming covered hereunder.

Section 2.2 Enrollment. The Plan Administrator may establish procedures in accordance with the Welfare Programs for the enrollment of Employees or their Dependents, or both, under the Plan. The Plan Administrator may prescribe enrollment forms (or an electronic equivalent) that must be completed by a prescribed deadline prior to commencement of coverage under the Plan.

Section 2.3 Special Enrollment Periods. The Plan shall comply with all provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") with regard to the extension of Special Enrollment Periods to an Employee, Dependent or Beneficiary to permit such individual(s) who would be otherwise eligible to enroll in the health benefit(s) offered under this Plan to enroll in the medical, dental or healthcare FSA benefits under this Plan, as described in Code Section 9801(f), as amended.

- (a) **Special Enrollment due to Loss of Other Coverage.** For an Employee and any Dependents of the Employee (including the Employee's spouse) who requests special enrollment (in writing) in this Plan as a result of a loss of other health coverage, as described below, the Plan will provide a period of 31 days to enroll under this Plan following the loss of other coverage. Enrollment will be otherwise subject to the eligibility provisions of each particular Welfare Program specified in Appendix A (which may condition Dependent enrollment on the enrollment of the Employee), and any such coverage under this Plan shall become effective, at the Employee's election, as of the date of the loss of other coverage or on the date of the Employee's notice, provided:
- (1) The individual(s) who request coverage in writing are otherwise eligible to enroll;
 - (2) The individual(s) for whom coverage is requested had other health coverage when coverage under the Plan was previously offered;
 - (3) The individual experiences a loss of other coverage due to:
 - (A) a legal separation or divorce;
 - (B) cessation of dependent status (such as attaining the maximum age permitted under the Plan);

- (C) death of the employee;
 - (D) a termination of employment or reduction in hours of employment;
 - (E) no longer residing, living or working in the service area, in the case of an HMO or other arrangement that does not provide benefits to individuals who no longer reside, live or work in the service area, but only if no other benefit package option is available to the individual;
 - (F) a situation in which a health and welfare plan no longer offers any benefits to a class of similarly situated individuals that includes the individual requesting coverage under this Plan;
 - (G) a termination of employer contributions for the other coverage; or
 - (H) exhaustion of COBRA continuation coverage, meaning coverage ceased other than due to a failure to timely pay premiums, or for cause (such as making fraudulent claims or an intentional misrepresentation of a material fact in connection with the Plan).
- (b) Special Enrollment due to Marriage, Birth, Adoption or Placement for Adoption. For an Employee and any Dependents of the Employee (including the Employee's spouse) who requests in writing special enrollment in this Plan as a result of the Employee's marriage or the birth of a child to the Employee or the adoption or placement for adoption of a child with the Employee, the Plan will provide a period of 31 days to enroll under this Plan following the marriage, birth, adoption or placement for adoption.
- (1) In the event of an Employee's marriage, coverage may be extended to the Employee, the Employee's new spouse and to any eligible dependent of the Employee or the new spouse, and such coverage will become effective, at the Employee's election, as of the date of the marriage or Employee notice.
 - (2) In the event of the birth of a child to the Employee or the adoption or placement for adoption of a child with the Employee, coverage may be extended to the Employee, and to any eligible dependent (including the Employee's spouse), and such coverage will be retroactively effective to the date of the child's birth, adoption or placement for adoption, provided the Plan Administrator timely receives a written request for special enrollment.
- (c) Special Enrollment due to changes in SCHIP or Medicaid. If an otherwise eligible Employee or Dependent of a Welfare Program specified in Appendix A that is a group health plan (1) loses coverage under a Medicaid Plan under Title XIX of the Social Security Act; (2) loses coverage under State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or (3)

becomes eligible for group health plan premium assistance under Medicaid or SCHIP, the Employee and eligible Dependents shall be entitled to special enrollment rights under the Plan. The request for enrollment must be provided in writing and must be made within 60 days from the date of the loss of other coverage or eligibility for premium assistance.

Section 2.4 Termination of Participant. A Participant will cease being a Participant in the Plan, and coverage under this Plan for the Participant and his Dependents and Beneficiaries shall terminate, in accordance with the provisions of the Welfare Programs.

ARTICLE III FUNDING AND BENEFITS

Section 3.1 Funding. Notwithstanding anything to the contrary contained herein, participation in the Plan and the payment of Plan benefits attributable to Employer or Participating Employer contributions shall be conditioned on a Participant's contributing to the Plan at such time and in such amounts as the Plan Administrator shall establish from time to time. The Plan Administrator may require that any Participant Contributions be made by payroll deduction. Nothing herein requires the Employer, a Participating Employer, or the Plan Administrator to contribute to or under any Welfare Program, or to maintain any fund or segregate any amount for the benefit of any Participant or a Dependent or Beneficiary, except to the extent specifically required under the terms of a Welfare Program. No Participant, Dependent or Beneficiary shall have any right to, or interest in, the assets of the Employer or any Participating Employer.

The Employer shall have no obligation, but shall have the right, to insure or reinsure, or to purchase stop-loss coverage with respect to any Welfare Program under this Plan. To the extent the Employer elects to purchase a fully-insured Welfare Program, any such benefits shall be the sole responsibility of the insurer, and the Employer and the Participating Employers shall have no responsibility for the payment of such benefits (except for refunding any Participant Contributions that were not remitted to the insurer). Except as otherwise permitted by rulings or regulations under ERISA, any Participant Contributions shall be remitted to the appropriate insurer, as soon as practicable but not later than ninety (90) days from the time such contributions are made and would otherwise have been paid to Participants in cash.

Section 3.2 Benefits. Benefits will be paid solely in the form and amount specified in the relevant Welfare Program and pursuant to the terms of such Welfare Program.

ARTICLE IV ADMINISTRATION AND FIDUCIARY PROVISIONS

Section 4.1 Named Fiduciary. The Plan shall be administered by one or more individuals or a Committee, as described in Section 1.3(d) of the Plan, who shall be appointed by the Employer to act as the Plan Administrator (as described in Section 3(16)(A) of ERISA) under

the Plan and such individuals shall be the named fiduciaries of the Plan (as described in Section 402(a)(2) of ERISA).

Section 4.2 Plan Administration. Except as otherwise provided in a Welfare Program:

- (a) The Plan Administrator shall have sole discretion and authority to control and manage the operation and administration of the Plan.
- (b) The Plan Administrator shall have complete discretion to interpret the provisions of the Plan, make findings of fact, correct errors, and supply omissions. All decisions and interpretations of the Plan Administrator made in good faith pursuant to the Plan shall be final, conclusive and binding on all persons, subject only to the claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious.
- (c) The Plan Administrator shall have all other powers necessary or desirable to administer the Plan, including, but not limited to, the following:
 - (1) To prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan;
 - (2) To prepare and distribute information explaining the Plan to Participants;
 - (3) To receive from Participating Employers and Participants, Dependents and Beneficiaries such information as shall be necessary for the proper administration of the Plan;
 - (4) To keep records of elections, claims, disbursements for claims under the Plan, and any other information required by ERISA or the Code;
 - (5) To appoint individuals or committees to assist in the administration of the Plan and to engage any other agents it deems advisable;
 - (6) To purchase any insurance deemed necessary for providing benefits under the Plan;
 - (7) To accept, modify or reject Participant elections under the Plan;
 - (8) To promulgate election forms and claims forms to be used by Participants;
 - (9) To prepare and file any reports or returns with respect to the Plan required by the Code, ERISA or any other laws;
 - (10) To determine and announce any Participant Contributions required hereunder;
 - (11) To determine and enforce any limits on benefits elected hereunder;

- (12) To take such action as may be necessary to cause payroll deduction of any Participant Contributions required hereunder; and
- (13) To correct errors and make equitable adjustments for mistakes made in the administration of the Plan; specifically, and without limitation, to recover erroneous overpayments made from the Plan to a Participant, Dependent or Beneficiary, in whatever manner the Plan Administrator determines is appropriate, including suspensions or recoupment of, or offsets against, future payments due that Participant, Dependent or Beneficiary.

Section 4.3 Delegation of Duties. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan, may designate fiduciaries other than those named in the Plan, and may allocate or reallocate fiduciary responsibilities under the Plan.

Section 4.4 Indemnification. The Plan Administrator and any delegate who is an employee of the Employer or a Participating Employer shall be fully indemnified by the Employer and by each Participating Employer against all liabilities, costs, and expenses (including defense costs, but excluding any amount representing a settlement unless such settlement is approved by the Employer) imposed upon it in connection with any action, suit, or proceeding to which it may be a party by reason of being the Plan Administrator or having been assigned or delegated any of the powers or duties of the Plan Administrator, and arising out of any act, or failure to act, that constitutes or is alleged to constitute a breach of such person's responsibilities in connection with the Plan, unless such act or failure to act is determined to be due to gross negligence or willful misconduct.

Section 4.5 Fiduciary Duties and Responsibilities. Each Plan fiduciary shall discharge his duties with respect to the Plan solely in the interest of the Participants and their Beneficiaries; for the exclusive purpose of providing benefits to such individuals and defraying reasonable expenses of administering the Plan; and in accordance with the terms of the Plan. Each fiduciary, in carrying out such duties, shall act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man or woman acting in a like capacity and familiar with such matters would use in exercising such authority. A fiduciary may serve in more than one fiduciary capacity. Unless liability is otherwise provided under Section 405 of ERISA, a named fiduciary shall not be liable for any act or omission of any other party to the extent that: (a) such responsibility was properly allocated to such other party as a named fiduciary, or (b) such other party has been properly designated to carry out such responsibility pursuant to the procedures set forth above.

ARTICLE V

CLAIMS AND APPEALS, SUBROGATION, COBRA AND HIPAA

Section 5.1 Claims Procedure. The Plan is intended to operate in compliance with the claims and appeals procedures of Section 2560.503-1 of the Department of Labor ("DOL") regulations, as amended from time to time. The claims and appeals procedures for each Welfare Program, as found in each Welfare Program's booklet, plan document, summary document or

certificate of coverage, shall be the claims and appeals procedures applicable to that Welfare Program. However, to the extent that a conflict exists between the terms of the Welfare Program document and the foregoing DOL regulations, the DOL regulations will control.

Section 5.2 Participant's Responsibilities. Each Participant shall be responsible for providing the Plan Administrator, Claims Administrator and/or the Employer with the Participant's and each Dependent's or Beneficiary's current address. Any notices required or permitted to be given hereunder shall be deemed given if directed to such address and mailed by regular United States mail. Neither the Plan Administrator, Claims Administrator nor the Employer shall have any obligation or duty to locate a Participant, Dependent or Beneficiary. In the event that a Participant, Dependent or Beneficiary becomes entitled to a payment under this Plan and such payment is delayed or cannot be made:

- (a) because the current address according to the Employer records is incorrect;
- (b) because the Participant, Dependent or Beneficiary fails to respond to the notice sent to the current address according to the Employer records;
- (c) because of conflicting claims to such payments; or
- (d) because of any other reason;

the amount of such payment, if and when made, shall be that determined under the provisions of this Plan without payment of any interest or earnings.

Section 5.3 Unclaimed Benefits. If, after any amount becomes payable hereunder to a Participant, Dependent or Beneficiary, the amount shall not have been claimed or any check issued under the Plan remains uncashed after a specified period of time, provided reasonable care shall have been exercised by the Plan Administrator in attempting to make such payments, the amount thereof shall be forfeited and shall cease to be a liability of the Plan. The specified period of time is: 3 months for UMR dental benefits, 12 months for Oxford medical benefits and 180 days for life, AD&D and long-term disability benefits.

Section 5.4 Right of Subrogation/Reimbursement. The subrogation/reimbursement provisions for each Welfare Program are found in each Welfare Program's booklet, plan document, summary document or certificate of coverage. However, to the extent that a Welfare Program's documentation does not include any subrogation or reimbursement provisions, this Section will control.

Notwithstanding anything to the contrary, the Plan is not obligated to pay any amounts otherwise payable or paid under this Plan as a result of medical expenses incurred by a Participant, Dependent or Beneficiary when the Participant, Dependent or Beneficiary recovers or has a claim to recover any funds from a third party (person or entity) potentially associated with such medical expenses (including proceeds from any insurance coverage payable with respect to the Participant, Dependent or Beneficiary), unless the Participant, Dependent or Beneficiary or his or her legal representative complies with this Section 5.4 and signs a subrogation/reimbursement agreement prior to the payment of any benefits. Payment by the Plan of any benefits prior to, or

without, obtaining a signed subrogation/reimbursement agreement shall not operate as a waiver of this subrogation/ reimbursement right.

For purposes of a subrogation/reimbursement agreement and Section 5.4, "third party" includes any other party's insurer, any payee of the other party or insurer and any insurer or indemnitor liable with respect to the Participant, Dependent or Beneficiary, including, without limitation, an insurer under a policy of "school" or "team" or "premises" or "owners, landlords or tenants" insurance or other specific risk, accident or health insurance or medical reimbursement coverage, an insurer under a policy of uninsured or underinsured motorist insurance, and any other party responsible in any way for providing compensation or indemnification arising as a result of the injury or sickness of a Participant, Dependent or Beneficiary. The Plan Administrator shall have the discretion to exercise any or all of its rights in any given case without setting any precedent.

The Participant, Dependent or Beneficiary agrees and acknowledges that any amounts which the Participant, Dependent or Beneficiary or his or her representative recovers from a third party in connection with such amounts advanced by the Plan (whether or not characterized as a recovery for injuries), up to the amount advanced by the Plan to the Participant, Dependent or Beneficiary or on his or her behalf, shall be held in trust or constructive trust for the benefit of the Plan, and that any action undertaken by the Plan or its fiduciaries to recover such amounts from the Participant, Dependent or Beneficiary shall be an action in equity seeking equitable remedies, which may be brought pursuant to Section 502 of ERISA.

The Plan shall be subrogated to all of the Participant, Dependent or Beneficiary's right of recovery of medical expenses against any person or organization. To the extent that the Plan pays medical expenses for which a Participant, Dependent or Beneficiary has a claim against a third party, the Plan is entitled to reimbursement out of any recovery from the third party, whether or not the Participant, Dependent or Beneficiary signs a subrogation/reimbursement agreement.

If a Participant, Dependent or Beneficiary makes a claim for benefits for which a third party may be responsible, the Plan may either: (1) pay all benefits covered under the Plan and obtain reimbursement for such benefits upon settlement with or judgment against the responsible third party, or (2) delay payment and require the third party to pay such benefits upon such settlement or judgment. As a condition of receipt of benefits paid by the Plan, the Participant, Dependent or Beneficiary must cooperate with the Plan and the Employer for the purpose of exercising such rights, claims or interest to recover the amount paid.

Whenever the Participant, Dependent or Beneficiary becomes aware that a third party is or may be liable for medical expenses paid or payable by the Plan, the Participant, Dependent or Beneficiary or his legal representative must:

- (a) Notify the Plan Administrator or other Plan agent of the identity of such third party (and liability insurer, if known), and the name, address and telephone number of the Participant, Dependent or Beneficiary's attorney;
- (b) Execute a subrogation/reimbursement agreement provided by the Plan Administrator or other Plan agent, as explained further below;

- (c) Notify the Plan Administrator or other Plan agent in writing of any settlement negotiations between the Participant, Dependent or Beneficiary and a third person, and submit a copy of the complaint or other initial pleading and subsequent pleadings in any action to recover damages from a third party;
- (d) Notify the Plan Administrator or other Plan agent of any court decision or settlement agreement concerning the third party's liability at the earliest possible date, and identify any parties from whom and to whom liability payments may be made, including any representative of the Participant, Dependent or Beneficiary such as an attorney or attorney-in-fact, trustee, or guardian;
- (e) Comply with the terms of the subrogation/reimbursement agreement.

The Plan may, but is not obligated to, take any legal action it sees fit against the third party or the Participant, Dependent or Beneficiary, to recover medical expenses the Plan has paid or may pay in the future.

In the event the Plan Administrator determines that there is a basis for recovery against the third party or against any payee of the third party, the Plan Administrator retains the right to employ the services of an attorney or other agent to recover money due to the Plan. The Participant, Dependent or Beneficiary and his or her legal representative agree to cooperate with the Plan's attorney. The compensation that the Plan's attorney or other Plan agent receives will be paid directly from the dollars recovered for the Plan from the third party.

The Plan's right to payment out of any third party liability recovery is prior to any right of payment of fees of the Participant, Dependent or Beneficiary's attorney. The Participant, Dependent or Beneficiary or his or her legal representative is obligated to inform his or her attorney or other agent of the Plan's rights under this Section 5.4 and to authorize no distributions from any settlement or judgment which will in any way result in the Plan's receiving less than the full amount of its lien, without the written approval of the Plan.

The Participant, Dependent or Beneficiary or his or her legal representative further agrees that he or she will not release any third party without prior written approval from the Plan, and will take no action which prejudices the Plan's rights under this Section 5.4.

The Plan may offset payment of any future claims otherwise payable to the Participant, Dependent or Beneficiary if the Participant, Dependent or Beneficiary chooses not to cooperate with all of the subrogation requirements.

Section 5.5 Amount of Recovery. The Plan's right to recover pursuant to Section 5.4 shall apply to an amount equal to the lesser of:

- (a) the benefits actually paid under the Plan for reimbursement of medical expenses plus any expenses incurred by the Plan in connection with asserting claims against the third party, the third party's payees or the Participant, Dependent or Beneficiary, or

- (b) the amount recovered by or on behalf of the Participant, Dependent or Beneficiary in connection with the act or omission of a third party. In doing so, all of such recovery shall be deemed to be as the result of medical expenses or other amounts paid on the claim by the Plan.

The Plan has a right of first reimbursement out of any recovery obtained by or on behalf of the Participant, Dependent or Beneficiary, even if the Participant, Dependent or Beneficiary is not made whole, regardless of how that recovery is classified or characterized. In addition, the Plan has a right to recover from the full amount of the recovery, before reduction for attorney's fees incurred by or on behalf of the covered person. The Plan is not bound by any "make-whole rule," "common fund rule," or similar rules that may otherwise apply under state law.

Section 5.6 COBRA Continuation Coverage and HIPAA. The Plan intends to comply with all applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Section 5.7 Untimely Claims. Unless otherwise specified in any applicable Welfare Program, all claims must be submitted to the Plan or Welfare Program for payment with complete information within a specified time from the date upon which such claim was incurred. That specified time is 15 months for dental claims, 6 months for out-of-network Oxford medical claims, 90 days for life, AD&D and long-term disability claims and 20 days for business travel accident claims. Claims submitted outside the applicable time limitation shall not be payable under the Plan or Welfare Program. This provision shall also apply to all claims made by providers, Participants, Dependents or Beneficiaries who assert that an improper amount was paid on a claim or that improper discounts were taken with respect to a claim, so that any such claim made after the specified time after the initial claim was incurred, shall not be payable under the Plan or Welfare Program.

ARTICLE VI
HIPAA PRIVACY COMPLIANCE

Section 6.1 Preamble. This Article is to allow any Welfare Program that provides group health benefits and is subject to HIPAA Privacy Rules (collectively referred to in this Article as the “Health Plan”) to disclose Protected Health Information (“PHI”) to the Employer in certain situations as permitted by HIPAA. References in this Article to disclosures from the Health Plans made to the Employer include disclosures to employees of the Employer, as described below.

Section 6.2 Disclosures of Summary Health Information. The Health Plan may disclose Summary Health Information to the Employer if the Employer requests this information in order to obtain premium bids for health insurance coverage under the Health Plan, or in order to modify, amend or terminate the Health Plan.

Section 6.3 Enrollment and Disenrollment Information. The Health Plan may disclose information to the Employer concerning whether or not an Individual is participating in the Health Plan, or has enrolled or disenrolled from a Health Insurance Issuer.

Section 6.4 Disclosures Pursuant to an Authorization. The Health Plan may disclose Protected Health Information to the Employer if the disclosure is made pursuant to a valid Authorization and the information is used as described in the Authorization. In particular, the Health Plan may disclose Protected Health Information to the Employer pursuant to an Authorization to assist employees and their beneficiaries in connection with their claims under the Health Plan, or to help them understand the terms of the Health Plan as they may relate to a particular condition or claim.

Section 6.5 Disclosures for Administration Purposes.

- (a) The Health Plan may disclose Protected Health Information to the Employer so it can carry out its Administration functions under the Health Plan. These functions include Payment and Health Care Operations, including without limitation, quality assurance, claims processing, processing and deciding appeals, claims auditing, claims monitoring, monitoring and managing carve-out plans such as vision and dental coverage, procuring stop-loss coverage, and reminding participants and beneficiaries of appointments or advising them of potential alternative treatments or services. For purposes of this Section, Administration functions do not include any employment-related functions or functions in connection with any other benefit or benefit plans of the Employer, and do not include any disclosures which otherwise conflict with the Privacy Rules. Disclosures of Protected Health Information for Health Plan Administration purposes may only be made if the conditions described in Sections 6.5(b) and 6.5(c) below are met.
- (b) The Employer must agree and comply with the following requirements before the Health Plan may disclose Protected Health Information to the Employer for Health Plans Administration purposes:

- (1) The use or disclosure must be described in the Health Plan's Notice of Privacy Practices issued pursuant to 45 CFR 164.520;
 - (2) The Employer must certify that the Health Plan documents have been amended as required by 45 CFR 164.504, and that it agrees to adhere to the requirements of these Amendments;
 - (3) The Employer may not use or further disclose Protected Health Information provided to it except as permitted by the Health Plan document (as amended to comply with HIPAA), or as required by law;
 - (4) The Employer will insure that any agents or subcontractors to whom it provides Protected Health Information received from the Health Plan will agree to the same restrictions and conditions on the use and disclosure of this information that apply to the Employer;
 - (5) The Employer will not use or disclose Protected Health Information received from the Health Plan for any employment-related actions or decisions, or in connection with any other benefit or benefit plan it maintains;
 - (6) The Employer will report to the Health Plan any use or disclosure of PHI which it has received from the Health Plan and which is inconsistent with allowed uses and disclosures, to the extent it becomes aware of such uses and disclosures;
 - (7) The Employer will make the Protected Health Information it receives from the Health Plan available to Individuals as required by 45 CFR 164.524 (pertaining to inspection and copying); 45 CFR 164.526 (pertaining to amendment); and 45 CFR 164.528 (pertaining to accounting);
 - (8) The Employer will make its internal practices, books and records relating to the use and disclosure of PHI it receives from the Health Plan available to the Secretary of Health and Human Services or his or her designee, to determine the Health Plan's compliance with the Privacy Rules;
 - (9) The Employer will, if feasible, return or destroy all Protected Health Information received from the Health Plan in any form, and retain no copies, when the information is no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, the Employer will limit further uses and disclosures of the Protected Health Information to those purposes which make the return or destruction infeasible.
- (c) The Employer must provide for adequate separation between itself and the Health Plan. Access to Protected Health Information shall be restricted so that only authorized persons receive only the minimum Protected Health Information necessary to accomplish the Administrative functions which he or she performs

for the Health Plans. If this person(s) or other employees of the Employer do not comply with the requirements of the Health Plans in respect to the use and disclosure of Protected Health Information, the Employer will impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. These sanctions will be imposed in accordance with the Employer's normal disciplinary policies, and can include termination of employment.

Section 6.6 No Other Disclosures of Protected Health Information. The Health Plan will not disclose Protected Health Information to the Employer (and will not cause a Health Insurance Issuer to disclose Protected Health Information to the Employer) except as described in this Article.

Section 6.7 Definitions.

- (a) Authorization. A document signed by an Individual authorizing disclosure of Protected Health Information and complying with the requirements of 45 CFR 164.508.
- (b) Health Care Operations. "Health Care Operations" mean:
 - (1) Any of the following activities of the Plan:
 - (A) conducting quality assessment and improvement activities, including outcomes evaluations and development of clinical guidelines specific to the Plan;
 - (B) population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination, contacting Health Care Providers and patients with information about treatment alternatives, and related functions which do not involve Treatment;
 - (C) reviewing the competence or qualification of health care professionals, evaluating practitioner or provider performance, training of students or practitioners in which the students or practitioners learn under supervision to practice or improve their professional skills, training non-health care professionals, and accreditation, certification, licensing or credentialing activities;
 - (D) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a health insurance contract or health benefits, as well as ceding, securing or placing a stop-loss or excess loss insurance contract relating to health claims (as long as the requirements of 45 CFR 164.514 are met);
 - (E) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

- (F) business planning and development, such as conducting cost-management and planning which pertain to running the Plan, including developing and administering formularies and administering, developing or improving methods of payment or coverage policies; and
- (G) business management and general Plan administrative activities, including but not limited to:
 - (i) management activities related to HIPAA privacy compliance;
 - (ii) customer service, including providing data analysis for plan sponsors, as long as PHI is not disclosed in the process;
 - (iii) resolution of internal grievances;
 - (iv) merger or consolidation of the Plan with another health plan, and due diligence related to the merger or consolidation; and
 - (v) consistent with the requirements of 45 CFR 164.514, creating de-identified health information or a limited data set.
- (c) Health Care Provider. The term “Health Care Provider” means a provider of services, including a provider of medical or health services, as defined in the Social Security Act, and any other person or organization that furnishes, bills, or is paid for health care in the normal course of business.
- (d) Health Information. “Health Information” means any information, whether oral or recorded in any form or medium, that:
 - (1) is created or received by a Health Care Provider, health plan, public health authority, the Employer, life insurer, school, university or health care clearing house; and
 - (2) relates to the past, present or future physical or mental health or condition of an Individual, the provision of health care to an Individual, or the past, present or future payment for the provision of health care to an Individual.
- (e) Health Insurance Issuer. The term “Health Insurance Issuer” means an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a state and is subject to state law that regulates insurance. The term does not include a group health plan.
- (f) Individual or Individuals. An “Individual” is the person who is the subject of PHI.

(g) **Individually Identifiable Health Information.** The term “Individually Identifiable Health Information” means Health Information, including demographic information, taken from an Individual which either identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.

(h) **Payment.** “Payment” means:

- (1) the activities of the Plan (or another health plan) to obtain premiums or to determine or fulfill its responsibility for coverage or providing benefits; or
- (2) the activities of the Plan or a Health Care Provider to obtain or provide reimbursement for providing health care.

Examples of Payment activities include, but are not limited to:

- (A) determination of eligibility or coverage, including coordination of benefits or determining cost sharing amounts;
- (B) determining subrogation of health claims;
- (C) risk adjusting amounts due based on an Individual’s health status and demographic characteristics;
- (D) billing, claims management, collection activities, obtaining payment under a stop-loss or excess loss insurance policy, and related health care data processing;
- (E) review of health care services to determine medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
- (F) utilization review activities, including precertification or preauthorization of claims and concurrent or retrospective review of services; and
- (G) disclosure to consumer reporting agencies of any of the following information relating to collection of premiums or reimbursement:
 - (i) name and address;
 - (ii) date of birth;
 - (iii) social security number;
 - (iv) payment history;
 - (v) account number; and

- (vi) name and address of the Plan or of a Health Care Provider.
 - (i) Privacy Rule or Rules. The terms “Privacy Rule” or “Privacy Rules” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, Subparts A and E.
 - (j) Protected Health Information. The term “Protected Health Information” means Individually Identifiable Health Information, excluding information contained in employment records of the Employer, that is transmitted or maintained in any form or medium.
 - (k) Summary Health Information. The term “Summary Health Information” means information that may be Individually Identifiable Health Information that summarizes the claims history, claims expenses, or type of claims experienced by Individuals under the Plan, and from which information described in 45 CFR 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.
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ARTICLE VII
HIPAA SECURITY COMPLIANCE

Section 7.1 Preamble. This Article modifies the Welfare Programs that provide group health benefits and are subject to HIPAA's Security Rules. For simplicity, these benefits are collectively referred to in this Article as the "Health Plan." This Article allows the Employer to create, receive, maintain or transmit Electronic Protected Health Information ("ePHI") in certain circumstances on behalf of its Health Plan.

Section 7.2 Safeguards. The Employer will put into place and follow Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any ePHI that the Employer creates, receives, maintains or transmits on behalf of the Health Plan, except as stated in Section 7.6 below.

Section 7.3 Adequate Separation. The Employer will put into place and follow reasonable and appropriate security measures to ensure that access to and use of ePHI is restricted to its employees or group of employees who are required to Access or use such ePHI for the proper administration of the Health Plan, or for such other reasons as may be proper under HIPAA Security Rules. The Employer will provide an effective mechanism for resolving any issues of non-compliance with such Security measures by ensuring that appropriate sanctions are imposed against any employee who violates or fails to follow them.

Section 7.4 Control of Agents and Subcontractors. The Employer will require that any of its agents or subcontractors to whom it provides ePHI relating to the Health Plan, agrees to implement reasonable and appropriate security measures to protect the ePHI.

Section 7.5 Reporting Security Incidents. The Employer will report to the Health Plan any Security Incident of which it becomes aware.

Section 7.6 Exceptions. The terms of this HIPAA Security Article shall not apply if ePHI is disclosed to the Employer pursuant to an Authorization which meets the requirements of the HIPAA Privacy Rules described at 45 CFR § 164.508, or if the ePHI is Summary Health Information which the Employer has requested in order (a) to obtain premium bids from health insurers for providing health insurance coverage under the Health Plan; or (b) to amend or terminate any of the Health Plan. In addition, the terms of this HIPAA Security Article shall not apply if the ePHI disclosed to the Employer is information concerning whether an Individual is participating in the Health Plan, or is enrolled or disenrolled from a health insurance issuer or HMO offered by the Health Plan.

Section 7.7 Definitions.

- (a) **Access.** "Access" means the ability or the means necessary to read, write, modify or communicate data/information or otherwise use any system resource.
- (b) **Administrative Safeguards.** "Administrative Safeguards" are administrative actions and policies and procedures, to manage the selection, development, implementation and maintenance of security measures to protect Electronic

Protected Health Information, and to manage the conduct of the Health Plan or their workforce in relation to the protection of that information.

- (c) Electronic Protected Health Information. “Electronic Protected Health Information” or “ePHI” is Protected Health Information which is transmitted by Electronic Media or maintained in Electronic Media. For this purpose the term “Electronic Media” means (i) electronic storage media, including memory devices and computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disc, optical disc or digital memory card; or (ii) transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including transmissions of paper, via facsimile and of voice, via telephone, are not considered to be transmissions via Electronic Media, because the information being exchanged did not exist in electronic form before the transmission.
- (d) Health Information. “Health Information” means any information, whether oral or recorded in any form or medium, that:
- (1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school, university or health care clearing house; and
 - (2) relates to the past, present or future physical or mental health or condition of an Individual, the provision of health care to an Individual, or the past, present or future payment for the provision of health care to an Individual.
- (e) HIPAA Privacy Rule or Rules. The terms “HIPAA Privacy Rule” or “HIPAA Privacy Rules” shall mean the Standards for Privacy of Individually Identifiable Health Information published at 45 CFR Parts 160 and 164, subparts A and E.
- (f) Individual. An “Individual” is the person who is the subject of Protected Health Information.
- (g) Individually Identifiable Health Information. The term “Individually Identifiable Health Information” means Health Information, including demographic information, taken from an Individual which either identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.
- (h) Physical Safeguards. “Physical Safeguards” are physical measures, policies, and procedures to protect the Health Plan’s electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion.

- (i) Protected Health Information. The term “Protected Health Information” means Individually Identifiable Health Information, excluding information contained in employment records of the employer, that is transmitted or maintained in any form or medium.
- (j) Security Incident. “Security Incident” means an attempted or successful unauthorized Access, use, disclosure, modification or destruction of information or interference with system operations in an information system.
- (k) Security Rule or Rules. Means the Security Standards for the protection of Electronic Protected Health Information published at 45 CFR Parts 160 and 164, subparts A and C.
- (l) Summary Health Information. The term “Summary Health Information” means information that may be Individually Identifiable Health Information that summarizes the claims history, claims expenses, or types of claims experienced by Individuals under the Health Plan, and from which information described in 45 CFR 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.
- (m) Technical Safeguards. “Technical Safeguards” mean the technology and the policies and procedures for its use that protect Electronic Protected Health Information and control Access to it.

ARTICLE VIII
AMENDMENT AND TERMINATION

Section 8.1 Amendment. The Employer has the right to amend the Plan at any time, including the right to amend any of the Welfare Programs or to transfer any Welfare Program from the Plan into a separate, related plan.

Section 8.2 Termination. The Employer may discontinue or terminate the Plan, in whole or in part, at any time, including termination of any one or more of the Welfare Programs.

ARTICLE IX
MISCELLANEOUS

Section 9.1 Headings. The Article and Section headings contained within this document are included only for convenience of reference, and should not be construed to limit or define the contents contained therein.

Section 9.2 Exclusive Benefit. This Plan has been established for the exclusive benefit of Participants, Dependents or Beneficiaries, and except as otherwise provided herein, all contributions under the Plan may be used only for such purpose.

Section 9.3 No Guaranty of Employment. The adoption and maintenance of the Plan shall not be deemed to be a contract of employment between the Employer and any Employee. Nothing contained in the Plan shall give any Employee the right to be retained in the employ of the Employer or to interfere with the right of the Employer to discharge any Employee at any time, nor shall it give the Employer the right to require any Employee to remain in its employ or to interfere with the Employee's right to terminate his employment at any time.

Section 9.4 Non-Alienation of Benefits. No benefit, right or interest of any Participant, Dependent or Beneficiary under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law or, in the case of assignments, as permitted under the terms of a Welfare Program.

Section 9.5 Gender and Number. Except as otherwise indicated by context, masculine terminology also includes the feminine, and vice versa, and terms used in the singular may also include the plural.

Section 9.6 Limitation of Rights. Neither the establishment nor the existence of the Plan, nor any modification thereof, shall operate or be construed as to:

- (a) give any person any legal or equitable right against the Employer or a Participating Employer, except as expressly provided herein or required by law, or

- (b) create a contract of employment with any Employee, obligate the Employer or a Participating Employer to continue the service of any Employee, or affect or modify the terms of an Employee's employment in any way.

Section 9.7 Severability. If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such invalid or unenforceable provision had not been included herein.

Section 9.8 Construction. The captions contained herein are inserted only as a matter of convenience and reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and other neuter are interchangeable.

Section 9.9 Expenses. Any expenses incurred in the administration of the Plan shall be paid by the Plan, by the Employer and/or by one or more Participating Employers, according to the Employer determination.

Section 9.10 Applicable Law. The Plan and all rights under the Plan shall be governed by and construed according to the laws of the State in which the Employer (or sponsor) of this Plan maintains its principal offices, except to the extent preempted by federal law.

ARTICLE X

PARTICIPATING EMPLOYERS

Section 10.1 Adoption of Plan. This Plan may be adopted by a Participating Employer, provided that such adoption is with the approval of the Employer.

Section 10.2 Administration. As a condition to adopting the Plan, and except as otherwise provided herein, each Participating Employer shall be deemed to have authorized the Plan Administrator to act for it in all matters arising under or with respect to the Plan and shall comply with such other terms and conditions as may be imposed by the Plan Administrator.

Section 10.3 Termination of Participation. Each Participating Employer may cease to participate in the Plan or in any Welfare Program with respect to its Employees or Former Employees by resolution of its governing body, if authorized to do so by the Employer, by resolutions of its Board of Directors.

IN WITNESS WHEREOF, St. John's University has caused this Plan restatement to be executed effective this _____ day of _____, 2014.

PLAN SPONSOR:

ST. JOHN'S UNIVERSITY

By: _____

Title: _____

Date: _____

APPENDIX A

WELFARE PROGRAMS OFFERED UNDER THE PLAN

The following Welfare Programs shall be treated as comprising the Plan pursuant to Section 1.3(q), defining "Welfare Program," as of the effective date of this Restatement. However, any Participating Employers who have adopted this Plan may not be eligible for all welfare benefit programs offered under this Plan:

PLANS INCORPORATED

- Medical Insurance
- Dental Insurance
- Life Insurance
- Accidental Death and Dismemberment Insurance
- Long-Term Disability Insurance
- Prepaid Legal Insurance
- Business Travel Accident Insurance
- St. John's University Flexible Spending Account and Premium Only Plan
 - Pre-Tax premium payment of medical and dental insurance premiums
 - Health Care Reimbursement Account
- Employee Assistance Plan

APPENDIX B

ELIGIBILITY PROVISIONS FOR THE WELFARE PROGRAMS OFFERED UNDER THE PLAN

- **MEDICAL INSURANCE** – Full-time employees (working 30 hours+/week) are eligible for coverage on the first day of the month coincident with or next following date of hire.
 - With regard to self-funded medical benefits, certain retirees are also eligible for medical insurance:
 - active, full-time staff or administrative employees who, at the time they retire are at least 55 years of age and have a minimum of 10 years of full-time service with the Employer, and the sum of their age and years of service with the Employer totals 75 years or more; or
 - active, full-time faculty employees who, at the time they retire are at least 65 years of age or are granted early retirement benefits pursuant to the applicable collective bargaining agreement.
 - With regard to self-funded medical benefits, certain disabled individuals are also eligible for medical insurance:
 - Participants may continue to participate in the self-funded medical benefits portion of the Plan during an approved long-term disability, under the same terms and conditions as an active employee, for a maximum period of 18 months (measured from the date of the approved long-term disability leave).
 - In the case of an administrative employee (and only administrative employees) who is not eligible for retiree coverage immediately following the 18-month disability leave coverage discussed above, the employee may be eligible to continue coverage under the Plan – at the employee’s own expense – as long as he or she (i) was working a minimum of 30 hours per week and has completed at least 25 years of service with the University, at the time he or she first became disabled (i.e., approved short-term disability leave); (ii) has been disabled for at least 24 months (including both short-term and long-term disabilities); and (iii) is disabled for purposes of the University’s long-term disability plan.
- **DENTAL INSURANCE** – Full-time employees (working 30 hours+/week) are eligible for coverage on the first day of the month coincident with or next following date of hire.
 - Certain retirees are also eligible for dental insurance:

- active, full-time staff or administrative employees who, at the time they retire are at least 55 years of age and have a minimum of 10 years of full-time service with the Employer, and the sum of their age and years of service with the Employer totals 75 years or more; or
 - active, full-time faculty employees who, at the time they retire are at least 65 years of age or are granted early retirement benefits pursuant to the applicable collective bargaining agreement.
- With regard to dental benefits, certain disabled individuals are also eligible for dental insurance:
 - Participants may continue to participate in the dental benefits portion of the Plan during an approved long-term disability, under the same terms and conditions as an active employee, for a maximum period of 18 months (measured from the date of the approved long-term disability leave).
 - In the case of an administrative employee (and only administrative employees) who is not eligible for retiree coverage immediately following the 18-month disability leave coverage discussed above, the employee may be eligible to continue coverage under the Plan – at the employee’s own expense – as long as he or she (i) was working a minimum of 30 hours per week and has completed at least 25 years of service with the University, at the time he or she first became disabled (i.e., approved short-term disability leave); (ii) has been disabled for at least 24 months (including both short-term and long-term disabilities); and (iii) is disabled for purposes of the University’s long-term disability plan.
- LIFE INSURANCE – Full-time employees (working 30 hours+/-week) are eligible for coverage on the first day of the month coincident with or next following date of hire.
 - Certain retirees are also eligible for life insurance:
 - active, full-time staff or administrative employees who, at the time they retire are at least 55 years of age and have a minimum of 10 years of full-time service with the Employer, and the sum of their age and years of service with the Employer totals 75 years or more; or
 - active, full-time faculty employees who, at the time they retire are at least 65 years of age or are granted early retirement benefits pursuant to the applicable collective bargaining agreement.

- **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE** - Full-time employees (working 30 hours+/week) are eligible for coverage on the first day of the month coincident with or next following date of hire.
 - **LONG TERM DISABILITY INSURANCE** – Full-time employees (working 30 hours+/week) are eligible for coverage on the one anniversary of their date of hire.
 - **PREPAID LEGAL INSURANCE** – Full-time employees (working 30 hours+/week) are eligible for coverage on the first day of the month coincident with or next following date of hire.
 - **BUSINESS TRAVEL ACCIDENT INSURANCE** – Full-time employees (working 30 hours+/week) are eligible for coverage on the first day of the month coincident with or next following date of hire.
 - **HEALTH CARE REIMBURSEMENT ACCOUNT** – Full-time employees (working 30 hours+/week) are eligible for coverage on the first day of the month coincident with or next following date of hire.
-