AMENDMENT

TO THE MISERICORDIA UNIVERSITY HEALTH AND WELFARE BENEFIT WRAP PLAN

This amendment is made by Misericordia University (the "Employer") to the Misericordia University Health and Welfare Benefit Wrap Plan (the "Plan"), effective April 1, 2018, as follows:

FIRST: Under Article 7, Section 7.4(c)(i) to (vi) (HOW TO APPEAL A DENIED GROUP HEALTH PLAN CLAIM) of the Plan is hereby deleted and replaced with the following:

(i) The specific reason or reasons for the adverse determination;

(ii) Specific references to the pertinent plan provisions on which the denial is based;

(iii) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record or other information is relevant to a claim for benefits shall be determined by reference to Section 503-1(m)(8) of ERISA;

(iv) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain information about such procedures described in Section 503-1(c)(3)(iv) of ERISA, and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following any final adverse benefit determination;

(v) A statement that a copy of any internal rule, guideline, protocol or other similar criteria relied upon in making the adverse benefit determination is available free of charge upon request;

(vi) A statement that if a denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limit, the Claim Fiduciary will, upon request, provide the claimant, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the plan to the claimant's medical circumstances; and

(vii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

SECOND: Under Article 7, Section 7.5 (DISABILITY CLAIMS) of the Plan is deleted in its entirety and replaced with the following:

Section 7.5 Disability Claims.

A disability claim is a claim that requires the Plan to determine if the claimant is disabled for purposes of eligibility for disability benefits under a Component Benefit Plan. Except as provided in this Section 7.5, the general claims procedures in Section 7.3 apply, including but not limited to the provisions relating to any Plan fiduciary's rights and responsibilities as provided in Section 7.3(c) and the claims limitation period identified in Section 7.3(d). Effective with respect to claims for disability benefits filed on or after April 1, 2018, an adverse benefit determination made with respect to disability benefits includes a rescission of disability coverage, as provided under Section 503-1(m)(4) of ERISA, that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(a) Time for a Decision on a Disability Claim. The Plan will notify the claimant of its determination within 45 days after its receipt of the claim. This period can be extended for two additional 30-day periods (up to a total of 105 days) if a decision cannot be made because of circumstances beyond the control of the Plan Administrator. If an extension of time is required, the claimant will be notified before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. If, prior to the end of the first 30-day extension period, the Claim Fiduciary determines that an additional extension is necessary due to matters beyond its control, the Claim Fiduciary may take up to an additional 30 days to review the claim. If an additional extension of time is required, the claimant will be notified before the end of the initial 30-day extension period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. If the Claim Fiduciary extends its period for reviewing a claim due to special circumstances, the notice of extension the claimant receives will include an explanation of the standards on which entitlement to benefits is based, the unresolved issues that prevent a decision on the claim and any additional information needed to resolve these issues. The claimant has at least 45 days to provide the specified information.

(b) Notification of Denial. If a claim for disability benefits filed prior to April 1, 2018 is denied, the Plan will notify the claimant of its initial claim determination in accordance with the procedures set forth in Section 7.4(b). If a claim for disability benefits on or after April 1, 2018 is denied, the claimant will receive written notice of denial that sets out the information below in a culturally and linguistically appropriate manner in accordance with Section 503-1(o) of ERISA:

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific Plan provisions on which the determination was made;

(iii) A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the Plan's review procedures and the time limits that apply to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) if the claim is denied on review;

(v) Where the determination is adverse, a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

a. The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational-professionals who evaluated the claimant;

b. The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

c. A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;

(vi) If the adverse 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 of such person or persons who conducted the initial claim determination;

(vii) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

(viii) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim.

(c) How to Appeal a Denied Disability Claim. The claimant may appeal the Plan's determination within 180 days following receipt of an adverse determination in accordance with the procedures set forth in Section 7.4(c). The Plan will notify

the claimant of its determination on review within 45 days. Under special circumstances, the Claim Fiduciary may take up to an additional 45 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the claimant will be notified in writing before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. The claimant has at least 45 days to provide the specified information.

(d) Notification of Benefit Determination on Review. For disability benefit claims filed prior to April 1, 2018, the claimant will receive written notice of the Plan's benefit determination on review which, in the case of an adverse benefit determination, contains the information provided in Section 7.4(c). For disability benefit claims filed on or after April 1, 2018, the claimant will receive written notice of the Plan's benefit determination on review that sets out the information below in a culturally and linguistically appropriate manner in accordance with ERISA Section 503-1(o):

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific Plan provisions on which the benefit determination is based;

(iii) 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;

(iv) A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under ERISA Section 502(a), including any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;

(v) Where the determination is adverse, a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

a. The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

b. The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice

was relied upon in making the benefit determination; and

c. A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;

(vi) 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 change upon request; and

(vii) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

(e) Additional Requirements for Disability Claims Filed on and after April 1, 2018. All claims and appeals for disability benefits must be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision; thus, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) must not be made based upon the likelihood that the individual will support a denial of benefits. Before a decision on review of a denied claim for disability benefits filed on or after April 1, 2018 may be made, the Plan Administrator shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which a notice of adverse benefit determination on review is required to be provided under applicable DOL regulations to give the claimant a reasonable opportunity to respond prior to that date. In addition, before a decision on review of a denied claim for disability benefits filed on or after April 1, 2018 may be made based on a new or additional rationale, the Plan Administrator shall provide the claimant, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under applicable DOL regulations to give the claimant a reasonable opportunity to respond prior to that date.

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IN WITNESS WHEREOF, the Employer has caused this amendment to be executed this ____ day of ________________, 2018 in its name and under its corporate seal by and through its duly authorized officer.

MISERICORDIA UNIVERSITY

By: ____________________________________

Title: ____________________________________