MISERICORDIA UNIVERSITY

SUMMARY OF MATERIAL MODIFICATION TO THE

MISERICORDIA UNIVERSITY HEALTH AND WELFARE BENEFIT WRAP PLAN

This Summary of Material Modification ("SMM"), effective April 1, 2018, amends the terms of your Summary Plan Description ("SPD") for the Misericordia University Health and Welfare Benefit Wrap Plan as follows:

FIRST: Under the section titled "Claims Procedures", subsection (c) "How to Appeal a Denied Group Health Plan Claim" paragraphs (1) to (6) are hereby deleted and replaced with the following:

(1) the specific reason or reasons for the denial;

(2) specific references to the pertinent plan provisions on which the denial is based;

(3) a statement that you are 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);

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

(5) 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;

(6) 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 you, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the plan to your medical circumstances; and

(7) 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: The paragraph under the heading "Special Rules for Disability Claims" is deleted and replaced with the following:

Special Rules for Disability Claims

A disability claim requires the Plan to determine if you are disabled for purposes of eligibility for disability benefits under a Component Benefit Plan. Except as provided under this heading, the general claims procedures under the heading "General Claims Procedure" apply, including but not limited to the provisions relating to any Plan fiduciary's rights and responsibilities as provided in paragraph (c) under the heading "General Claims Procedure" and the claims limitation period identified in paragraph (d) under the heading "General Claims Procedure".

Time for a Decision on a Disability Claim

The Plan will notify you of its determination within 45 days after its receipt of your 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 the Claim Fiduciary extends its period for reviewing a claim due to special circumstances, the notice of extension you receive 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. If more information is requested during either extension period, you will have at least 45 days to supply it.

Notification of Denial

The Plan will notify you of its initial claim determination in accordance with the procedures described in paragraph (b) under the heading "Special Rules for Group Health Plan Claims". 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 an easy to understand manner in accordance with Section 503-1(o) of ERISA:

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

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

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

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

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

> (1) The views present by you to the Plan of health care professional treating you and vocational-professionals who evaluated you;
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> (2) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
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> (3) A disability determination made by the Social Security Administration regarding you (as the claimant) presented by you to the Plan;

(f) 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 your

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;

(g) 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

(h) A statement that you are 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.

How to Appeal a Disability Claim

You may appeal the Plan's determination within 180 days following receipt of an adverse determination in accordance with the procedures described in paragraph (c) under the heading "Special Rules for Group Health Plan Claims". The Plan will notify you of its determination on review within 45 days and in accordance with the procedures in paragraph (b) under the heading "General Claims Procedure." Otherwise, the general claims procedures apply, including the provisions relating to any Plan fiduciary's rights and responsibilities and the claims limitation period. 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, you 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. You have at least 45 days to provide the specified information.

Notification of Benefit Determination on Review

For disability benefit claims filed prior to April 1, 2018, you 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 paragraph (c) under heading "Special Rules for Group Health Plan Claims". For disability benefit claims filed on or after April 1, 2018, you 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):

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

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

(c) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

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

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

(1) The views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you;

(2) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(3) A disability determination regarding you presented by you to the Plan made by the Social Security Administration;

(f) 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 your medical circumstances, or a statement that such explanation will be provided free of change upon request; and

(g) 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.

Additional Requirements for Disability Claims Filed on or 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 you, 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 you 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 you a reasonable opportunity to respond prior to that date.

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For details regarding these changes, see the 2018 updated Certificates of Coverage or similar documents for the applicable Component Benefit Plan. Official plan documents control the actual payment of benefits and the administration of this Plan. This SMM merely highlights the changes and does not replace those documents. **In case of any discrepancy, the official Plan document (including any and all amendments to the Plan) will control.**

Please keep this important Summary of Material Modification with your Summary Plan Description.