UNIVERSITY OF CHICAGO
GROUP LIFE AND DISABILITY PLAN

TABLE OF CONTENTS

I. PURPOSE 3
II. DEFINITIONS 3
III. ADMINISTRATION OF THE PLAN 5
3.1 Plan Administration 5
3.2 Delegation of Duties 6
3.3 Compensation and Expenses 6
3.4 Claims Administrator 6
3.5 Plan Interpretation 6
IV. ELIGIBILITY 7
V. BENEFITS 7
VI. CONTRIBUTIONS 8
6.1 Employer Contributions 8
6.2 Employee Contributions 8
6.3 Funding 8
VII. MISCELLANEOUS 8
7.1 Information to be Furnished by Covered Employees 8
7.2 Records 9
7.3 Uniform Rules 9
7.4 Claims Procedures 9
7.5 Plan Administrator's Decision Final 13
7.6 Action by the University 14
7.7 Indemnification 14
7.8 Benefit Checks, Drafts or Other Forms of Claim Payment non Presented for Payment 14
7.9 Funding Policy 15
7.10 Waiver of Notice 15
7.11 Gender and Number 15
7.12 Controlling Law 15
7.13 Interests Not Transferable 15
7.14 Facility of Payment 15
7.15 No Vested Interest 16
7.16 Employment Rights 16
7.17 Evidence 16
7.18 Physical Examination and Autopsy 16
7.19 Recovery of Benefits 16
7.20 No Waiver of Plan Provisions 16
7.21 Effect on Workers' Compensation 16
7.22 Headings 17
7.23 Successors and Assigns 17
7.24 No Guarantee of Tax Consequences 17
7.25 Correction of Errors 17
7.26 Invalidity of Certain Provisions 17
VIII. AMENDMENT AND TERMINATION 17
8.1 Amendment 17

8.2 Termination 17
IX. ADDITIONAL EMPLOYERS .....**Error! Bookmark not defined.**

EXHIBIT A – Plan Documents 19

I. PURPOSE

The University of Chicago (the "University") has provided life insurance and long term disability benefits to eligible Employees and their Dependents pursuant to The University of Chicago Group Life Insurance Plan and The University of Chicago Long Term Disability Plan, both originally effective July 1, 1964 and amended from time to time thereafter. Effective January 1, 2019, The University of Chicago Group Life Insurance Plan is hereby merged into, and shall become a single plan for reporting and disclosure purposes with, The University of Chicago Group Long Term Disability Plan (Plan No. 509) and both such plans as amended and restated shall be renamed the University of Chicago Group Life and Disability Plan (the "Plan").

The Plan shall consist of this document and the documents set forth in Exhibit A (the "Benefit Program Documents"). The Plan hereby incorporates by reference the applicable life insurance and long term disability provider contracts or insurance agreements and certificates of coverage, as amended from time to time. The Plan shall be treated as a single employee welfare benefit plan intended to meet all the requirements of ERISA and the Code, with designation for reporting and disclosure purposes as Plan No. 509.

II. DEFINITIONS

2.1 "Beneficiary" means the beneficiary or beneficiaries designated by a Participant pursuant to the terms of the Plan to receive the amount, if any, payable under the Plan, upon the death of an individual covered under the Plan.

2.2 "Board" means the Board of Trustees of the University, or a duly appointed committee thereof, as each may from time to time be constituted.

2.3 "Claims Administrator" means the Plan Administrator or such entity or entities as may be appointed from time to time by the University to process benefit payments or to administer all or a portion of the claims and appeals procedures under the Plan.

2.4 "Code" means the Internal Revenue Code of 1986, as amended from time to time, and the applicable regulations and rulings thereunder.

2.5 "Dependent" means an individual who meets the requirements for "dependent" coverage specified under the Plan.

2.6 "Employee" means a common-law employee of the Employer who is eligible to become a Participant under the Plan. If any worker is classified by the Employer as a leased employee, independent contractor or any other classification not eligible to participate in a Plan, and the Employer subsequently is required by the Internal Revenue Service, U.S. Department of Labor or other governmental agency, or any court or other tribunal, to reclassify any such worker as a common-law employee, such worker will not be eligible to participate in the Plan unless and

until the time he or she is specifically designated by the Employer as eligible. Such designation shall provide for eligibility only prospectively from the time the designation is made.

2.7 "Employer" means the University.

2.8 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time, and the applicable regulations and rulings thereunder.

2.9 "Named Fiduciary" means a named fiduciary within the meaning of Section 402(a)(2) of ERISA.

2.10 "Participant" means an Employee enrolled in the Plan.

2.11 "Plan Administrator" means the University, unless the University names another person or entity as the plan administrator.

2.12 "Plan" means the University of Chicago Group Life and Disability Plan, as described herein, and as amended from time to time.

2.13 "Plan Year" means the 12-month period ending on each December 31.

III. ADMINISTRATION OF THE PLAN

3.1 Plan Administration. The Plan Administrator will be the "plan administrator" and Named Fiduciary of the Plan and will be responsible for the general administration of the Plan. The Plan Administrator has the authority to exercise all the powers and discretion conferred on it by the Plan as may be necessary to control and manage the operation and administration of the Plan and to discharge its duties hereunder, including, but not by way of limitation, the following:

(a) to construe and interpret the Plan, decide all questions of eligibility, and determine the amount, manner and time of payment of any benefits;

(b) to prescribe procedures to be followed by Participants filing applications for participation and benefits;

(c) to prepare and distribute, in such manner as it determines to be appropriate, information explaining the Plan;

(d) to receive from the Employer and from Participants such information as will be necessary for the proper administration of the Plan;

(e) to furnish the Employer, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate;

(f) to appoint or employ individuals to assist in the administration of the Plan, and to appoint or employ any other agents it deems advisable, including legal counsel;

(g) to establish, from time to time, rules, regulations and interpretations for the administration of the Plan, and the transaction of the Plan's business, and to change, alter, or amend such rules, regulations and interpretations;

(h) to make all reports or other filings necessary for the Plan to meet both the reporting and disclosure requirements and other filing requirements of ERISA that are the responsibility of "plan administrators" under ERISA;

(i) to monitor any fiduciary to whom it has delegated, or any Named Fiduciary to whom it has allocated, fiduciary duties;

(j) to make available to any Participant upon request, for examination during business hours, such records as pertain exclusively to the examining Participant; and

(k) to direct, in its discretion, that Plan assets be used to pay fees, premiums or compensation under the Plan, or to acquire insurance or other contracts issued by an insurance company or other entity that provides benefits or that provides insurance protection with respect to such benefits, or to amend, modify, supplement, or terminate such contracts as selected and determined from time to time.

All findings of fact, determinations, interpretations, and decisions of the Plan Administrator will be conclusive and binding upon all persons having or claiming to have any

interest or right under the Plan. Notwithstanding the foregoing, the Plan Administrator's authority under this Section 3.1 shall not extend to any matter as to which an administrator or another designated party under any benefit provided herein is empowered to make decisions, and any claim that arises under a benefit with its own separate administrative and claims procedures shall not be subject to review under this Plan.

3.2 Delegation of Duties. The Plan Administrator may designate other organizations, entities, or persons (who also may be employed by the Employer) to carry out its specific fiduciary responsibilities in administering the Plan including, but not limited to, the following:

(a) the responsibility for administering and managing the Plan, including the processing and payment of benefits under the Plan and the recordkeeping related thereto;

(b) the responsibility to prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to Employees, Participants or other persons entitled to benefits under the Plan; and

(c) the responsibility to review claims or claim denials under the Plan.

3.3 Compensation and Expenses. The Plan Administrator will serve without compensation for services as such. The Plan Administrator may receive reimbursement by the Plan of expenses properly and actually incurred in the administration of the Plan, to the extent not paid by the Employer. Such expenses will include any expenses incident to the administration of the Plan, including, but not limited to, fees of accountants, counsel and other specialists.

3.4 Claims Administrator. The Claims Administrator will make all determinations regarding the right of any person to a benefit under the Plan, and the amount and payment of any benefit. In such event, the Claims Administrator has the right to make any finding of fact necessary or appropriate under the Plan to determine eligibility for and the amount of any benefit payable under the Plan. In addition, the Plan Administrator may delegate to the Claims Administrator discretionary authority to interpret the terms and provisions of the Plan and to determine questions arising in connection with the administration of claims under the Plan, and the right to remedy or resolve possible ambiguities, inconsistencies, or admissions, by general rule or particular decision. The Claims Administrator will follow the procedures for filing claims set out in the Plan. In addition, the Claims Administrator may establish additional reasonable procedures as necessary for administering the Plan. In accordance with such procedures, when a claim has been verified and approved, benefits will be paid to the covered person, his or her Beneficiary, or directly to the care provider, as the case may be. To the extent permitted by law, all findings of fact, determinations, interpretations and decisions of the Claims Administrator will be conclusive and binding upon all persons having or claiming to have any interest or right under the Plan.

3.5 Plan Interpretation. The provisions of all documents comprising the Plan shall be interpreted to the extent possible to give meaning to all provisions in all documents comprising the Plan. In the event of any irreconcilable conflict between or among provisions of different documents comprising this Plan, the provisions of the documents shall be given priority in the following order of preference, unless explicitly provided otherwise herein or as otherwise

determined by the Plan Administrator, with such determination being final and binding on all parties:

(a) This document.

(b) Benefit Program Documents, including applicable agreements, contracts and policies executed by third parties (for example, insurance policies and riders and certificates of coverage).

(c) The most recent summary(ies) of material modifications (as that term is defined in ERISA) modifying the terms of the most recently published summary plan description.

(d) The most recently published summary plan description.

IV. ELIGIBILITY

Each Employee (and his or her Dependents) will be covered, and will be eligible for the benefits provided by the Plan, solely in accordance with the terms of the Benefit Program Documents applicable to the group or classification of Employees of which such Employee is a member, set forth in Exhibit A and incorporated herein by reference.

V. BENEFITS

5.1 Incorporation by Reference. The benefits provided under the Plan for each group or classification of Employees, and the covered Dependents of such Employees, are those set forth in the Benefit Program Documents, set forth in Exhibit A and incorporated herein by reference.

5.2 Beneficiary Designations. The University may not be designated as a Beneficiary. Additionally, the Participant shall automatically be the Beneficiary for any life insurance coverage of a Dependent.

5.3 Controlling Effect of Plan Benefits. The provisions of a benefit provided under the Plan, such as the types and amounts of benefits, the procedures for the payment of benefits, and any other conditions or limitations on benefits shall be determined under the Benefit Program Documents except as expressly provided in the Plan or by the University, by action of its Board of Trustees (or an officer or employee who has delegated authority from the Board of Trustees to perform this function).

5.4 Life Insurance Benefits. If, on or after January 1, 2018, a Participant's life insurance coverage under the Plan terminates due to the expiration of the coverage continuation period upon an approved leave of absence and the Participant is receiving long-term disability benefits under the Plan at the time of such termination, the Participant may continue his or her life insurance coverage under the Plan for up to an additional 18 months if the Participant makes timely payment

to the University of the portion of the premium required to continue his or her life insurance in force under the Plan and the University accepts such payment, subject to the other terms of the Plan. This Section 5.4 does not apply to dependent life insurance benefits and shall apply only to Participants whose date of disability for purposes of receiving long-term disability benefits under the Plan occurs on or prior to February 28, 2016.

VI. CONTRIBUTIONS

6.1 Employer Contributions. For each Plan Year, the Employer will make such contributions under the Plan in such amounts and at such times as the Plan Administrator determines are appropriate to fund the Plan.

6.2 Employee Contributions. As a condition of eligibility under the Plan, an Employee may be required to make such contributions in such amounts and at such times specified by the Plan Administrator in accordance with the terms of the Plan, applicable to the coverage option selected and the group or classification of Employees of which such Employee is a member. Employee contribution requirements may be increased or decreased from time to time. An Employee's contributions shall be made either:

(a) pursuant to a compensation reduction election made in accordance with the University's cafeteria plan; or

(b) in such other manner as the Plan Administrator specifies.

6.3 Funding. Benefits under the Plan may be paid pursuant to an insurance contract, from a trust established for such purpose, or out of the general assets of the Employer.

VII. MISCELLANEOUS

7.1 Information to be Furnished by Covered Employees. Employees and Dependents covered under the Plan must furnish the Plan Administrator with such evidence, data or information as the Plan Administrator considers necessary or desirable to administer the Plan. Notwithstanding anything contained in the Plan to the contrary, the Plan Administrator will have the authority and power to (i) terminate the participation of, (ii) prohibit participation or eligibility of, or (iii) refuse payment or reimbursement for claims incurred by, any individual who has engaged in improper conduct with respect to the Plan, to the extent permitted by law. "Improper conduct" includes, but is not limited to, a deliberate action, statement or omission of an individual, intended to or resulting in the individual directly or indirectly receiving coverage, payment or reimbursement of benefits under the Plan, where such coverage, payment or reimbursement would not otherwise have been available had the individual not engaged in the improper conduct. Improper conduct also includes, but is not limited to, misrepresentations and acts of fraud with respect to eligibility for Plan participation, claims for services not performed or not authorized by the appropriate provider, and failure to notify the Plan, or representatives of the Plan, of a fact or

an event which could affect the individual's rights to receive coverage, payment or reimbursement under the Plan.

7.2 Records. As a condition of receiving benefits payable under the Plan, a Participant or Beneficiary may be required to provide the Plan Administrator or Claims Administrator with such evidence and records in such form as the Plan Administrator or Claims Administrator specifies.

7.3 Uniform Rules. The Plan Administrator will administer the Plan on a reasonable and nondiscriminatory basis and will apply uniform rules to all persons similarly situated.

7.4 Claims Procedures. Claims and appeals for benefits under the Plan shall be made applicable procedures detailed in the Benefit Program Documents. Claims shall be evaluated by the Plan Administrator or such other person or persons to whom such authority has been delegated. However, in the absence of an applicable claims procedure, then the following claims and appeals procedures shall apply.

For purposes of these claims and appeals procedures, electronic notification from the Claims Administrator serves as written notification in accordance with applicable Department of Labor regulations. A claimant may exercise his or her rights directly or through an authorized representative. If a claimant chooses to appoint an authorized representative, the claimant must submit a written statement to the Claims Administrator designating the authorized representative to act on the claimant's behalf with respect to a claim. A claimant may have only one representative at a time to assist in submitting an individual claim or appealing an unfavorable claim determination. An assignment or attempted assignment of a claim for benefits does not constitute a designation of an authorized representative. Such a delegation must be clearly stated in a form acceptable to the Claims Administrator. In certain circumstances, an authorized representative may be required to produce evidence of his or her authority to act on the claimant's behalf and the Plan may require the claimant to execute a form relating to such representative's authority before that person will be given access to the claimant's protected health information or allowed to take any action on the claimant's behalf.

(a) **Determination of Initial Claim**. If a claim for benefits is denied, in whole or in part, notice of the decision shall be made to the claimant within a reasonable period of time, but not more than 90 days (45 days if the claim is for disability benefits) after the receipt of a properly submitted claim, unless special circumstances require an extension of time for processing the claim. If the Claims Administrator determines that an extension of time for processing the claim is required, the extension shall not exceed an additional 90 days. In the case of a claim for disability benefits, the 45-day review period may be extended for up to two additional 30-day periods if necessary due to circumstances beyond the Claims Administrator's control. A written notice of the extension, the reason for the extension, and the date by which the Plan expects to decide the claim shall be furnished to the claimant within the otherwise applicable review period. However, if a period of time is extended due to the claimant's failure to submit information necessary to decide the claim, the period for making the benefit determination will be tolled from the date on which the

notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

If the claim for benefits is denied, in whole or in part, the claimant or his or her authorized representative will receive a written or electronic notice of the denial. The notice shall include:

(1) the specific reason(s) for the denial;

(2) references to the specific Plan provisions on which the benefit determination was based;

(3) a description of any additional material or information necessary for the claimant to perfect a claim and an explanation of why such information is necessary, and

(4) a description of the appeals procedures and applicable time limits, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following appeal of the claim.

(5) In addition, if the initial claim is for disability benefits, the notice also will set forth:

(A) a discussion of the decision, including reasons for disagreeing with, or not following:

(i) the views presented by the claimant to the Plan of any health care professionals and vocational professionals who evaluated the claimant,

(ii) the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination, and

(iii) a disability determination regarding made by the Social Security Administration that the claimant presented to the Plan.

(B) any internal rule, guideline, protocol, or other similar criterion relied upon in denying the claim for disability benefits, or a statement that any such internal rule, guideline, protocol, or other similar criterion does not exist,

(C) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will

be provided free of charge upon request, or a statement that such explanation will be provided free upon request, and

(D) 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.

(b) **Appeals of Adverse Determination**. If a claim for benefits is denied, in whole or in part, or if the claimant does not receive a response to his or her claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), the claimant may appeal the denied claim in writing to the Claims Administrator within 60 days (180 days in the case of a claim for disability benefits) of the receipt of the written notice of denial or the date such claim is deemed denied. The claimant may submit with the appeal any written comments, documents, records and any other information relating to the claim. Upon request, the claimant will also have access to, and the right to obtain copies of, all documents, records and information relevant to the claim free of charge. The Claims Administrator's review will take into account all comments, documents, records, and other information submitted by the claimant, without regard to whether such information was submitted or considered in the initial benefit determination.

If the claim is for disability benefits, the claimant will have the following rights in addition to those set forth in the preceding paragraph:

(1) The review of a denied claim will be made by someone other than the original decision maker(s) and such person(s) will not be a subordinate of the original decision maker(s). The claim will be reviewed without deference to the initial adverse benefit determination.

(2) If the initial adverse benefit determination was based in whole or in part on a medical judgment (including any determination as to whether a treatment is experimental or not medically necessary), the appeals administrator will consult a health care professional with appropriate training and experience in the field of medicine involving the medical judgment. The health care professional who is consulted on appeal will not be the same individual who was consulted during the initial determination or the subordinate of such individual. If the Claims Administrator obtained advice of medical or vocational experts in making the initial adverse benefits determination (regardless of whether the advice was relied upon), the appeals administrator will identify such experts.

(3) Before the Plan can issue an adverse determination on a review of a claim for disability benefits, the appeals administrator will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, or any other person making the benefit determination (or at the direction of the Plan or such other person) in connection with the claim. If the adverse determination on review is based on a new or additional rationale, the appeals administrator will provide the claimant, free of charge, with the new or

additional rationale. Any such new or additional evidence or new additional rationale will 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, in order to give the claimant a reasonable opportunity to respond prior to that date.

(c) **Determination of Appeal.** The Claims Administrator shall make a determination on a claim appeal within 60 days of the receipt of the appeal request, unless special circumstances require an extension of time for procession, in which case a decision shall be rendered within 120 days after the Claims Administrator's receipt of the appeal request. If an extension of time is necessary because of special circumstances, the Claims Administrator shall give written or electronic notice of the extension, the reason for the extension, and the date that the Claims Administrator expects to render a decision shall be furnished to the claimant. In the case of a review of a denied claim for disability benefits, the appeals administrator shall make a determination on the claim appeal within 45 days of the receipt of the appeal request. This period may be extended by up to an additional 45 days if special circumstances require an extension of time and the appeals administrator provides written or electronic notice to the claimant of the need for the additional period of time prior to the expiration of the initial 45-day period.

If the claim on appeal is denied in whole or in part, the claimant will receive a written or electronic notification of the denial. The notice will be written in a manner calculated to be understood by the claimant and shall include:

(1) the specific reason(s) for the adverse determination,

(2) references to the specific Plan provisions on which the determination was based,

(3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and make copies of, all records, documents and other information relevant to the benefit claim,

(4) a statement describing any appeals procedures offered by the Plan, and the claimant's right to bring a civil suit under Section 502(a) of ERISA, and

(5) if applicable, 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."

(6) In addition, if the appeal is for disability benefits, the notice also will set forth:

(A) a discussion of the decision, including any reasons for disagreeing with, or not following: (i) the views presented by the claimant to the Plan of any health care professionals treating the claimant and

vocational professionals who evaluated the claimant, (ii) the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination, and (iii) a disability determination regarding the claimant made by the Social Security Administration that the claimant presented to the Plan,

(B) 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 criterion of the Plan do not exist,

(C) if the denial of the claim for disability benefits was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free upon request, and

(D) a description of any contractual limitations period that applies to the claimant's right to bring such an action (with the calendar date on which any contractual limitations period, if any, that may apply to the claim will expire).

If a decision on appeal is not furnished to the claimant within the time frames mentioned above, the claim shall be deemed denied on appeal.

(d) **Legal Actions**. The claims and review procedures described herein must be utilized and fully exhausted before a claimant may bring a legal action against the University, the Employer, the Plan Administrator, Claims Administrator, or the Plan and, unless the Plan or Benefit Program Document provides otherwise, any such legal action must be filed within two (2) years of receiving final notice of the benefit. The exhaustion requirement applies to all types of claims under the Plan, including: (i) recovery of benefits under the Plan, (ii) enforcement of rights under the terms of the Plan, and (iii) clarification of rights to future benefits under the terms of the Plan.

7.5 Plan Administrator's Decision Final. The Plan Administrator has discretionary authority to determine eligibility for benefits, to interpret the Plan and all of their terms and provisions, including, without limitation, the right to remedy ambiguities, inconsistencies, or omissions, by general rule or particular decision, and to determine the amount, manner, and time of payments of any benefits under the terms of the Plan. The Plan Administrator may delegate all or part of such authority to a Claims Administrator appointed under Article III. Subject to applicable law, any interpretation of the provisions of the Plan and any decisions on any matter within the discretion of the Plan Administrator made by the Plan Administrator in good faith shall be binding on all persons. A misstatement or other mistake of fact will be corrected when it becomes known, and the Plan Administrator will make such adjustment on account thereof as it

considers equitable and practicable. The Plan Administrator will not be liable in any manner for any determination of fact made in good faith.

7.6 Action by the University. Any action required or permitted to be taken by the University under the Plan will be by written instrument adopted by the Board or its authorized delegate.

7.7 Indemnification. To the maximum extent permitted by law, the Named Fiduciaries, Plan Administrator, and all agents and representatives of the Employer (including its Employees) will be indemnified by the University, and saved harmless against any claims, losses, liabilities, costs, fines, penalties, and expenses (including attorneys' fees), resulting from any actual or alleged action, conduct, or failure to act relating to the administration of the Plan, except for claims arising from gross negligence, willful neglect, willful misconduct, or lack of good faith, or from conduct that has resulted in the receipt of personal profit or advantage to which such party is not entitled. Parties may be indemnified under this Section 7.7 to the extent not indemnified or saved harmless under any liability insurance or any other indemnification arrangement with respect to the Plan.

In connection with the indemnification provided by this Section 7.7, expenses incurred in defending a civil or criminal action, suit or proceeding, or incurred in connection with a civil or criminal investigation, may be paid by the University in advance of the final disposition of such action, suit, proceeding, or investigation, as authorized by the University in the specific case, and will be paid with respect to any such expenses relating to any action or portion of an action brought against the Plan Administrator, upon receipt of a written contract by or on behalf of the party to be indemnified to repay such amount if it is ultimately determined that the party is not entitled to be indemnified pursuant to this Section 7.7. Notwithstanding the foregoing, the University will not indemnify a party for any amount incurred through settlement or compromise of any action unless the University consents in writing to such settlement or compromise.

7.8 Benefit Checks, Drafts or Other Forms of Claim Payment not Presented for Payment. Except as otherwise provided in the Benefit Program Documents, to the extent the Plan, any third party vendor, or administrator issues and/or forwards a check, draft, or other form of claim payment ("benefit payment") to the last known address of a Participant or Beneficiary, and the Participant or other person or provider fails to cash, present for payment or otherwise tender the benefit payment within the twenty-four (24) month period immediately following the date such benefit payment was issued or forwarded by or on behalf of the Plan (and without regard to its actual receipt by a Participant or other person), the Participant's or other person's entitlement to such benefit payment shall be immediately cancelled. The Participant, other covered person, or provider shall have no further right or entitlement to such benefit payment except as provided herein or required by law. In the event that such amounts represent Plan assets, they shall be used toward future benefit payments and any state laws regarding escheatment or similar matters shall be pre-empted to the fullest extent provided by ERISA.

If any benefit payment is cancelled under this Section 7.8 the Participant or other person may apply to the Plan to have such benefit payment reinstated, provided that the appropriate claim information is presented to the Plan Administrator. The Plan Administrator may prescribe uniform nondiscriminatory rules for carrying out this provision.

7.9 Funding Policy. The University shall establish and carry out a funding policy and method consistent with the objectives of the Plan and the requirements of ERISA. Such funding policy may be amended by the University from time to time. The benefits under the Plan may be funded through the purchase of insurance policies or contracts, the general assets of the Employer, any employee contributions as may be required, or any combination of the foregoing. Any portion of the Plan that has its benefits funded through the purchase of one or more insurance policies or contracts is considered an insured component of the Plan. Any portion of the Plan that is not funded through the purchase of any insurance policy or contract is considered a self-funded component of the Plan. In the event of the termination of a self-funded component of the Plan, there are no specific assets set aside to use to pay claims incurred prior to the date of such termination. If a self-funded component of the Plan should be terminated, only claims incurred prior to the date of such termination would be paid by the Plan with respect to such component, and only to the extent such program is then funded or the claims are paid by the Employer. Nothing herein requires the Employer or the Plan Administrator to contribute to or maintain any fund or segregate any amount for the benefit of any Participant or Dependent.

Any dividends, retroactive rate adjustments, rebates, or other refunds of any type that may become payable under any such policies or contracts or in connection with the Plan shall not be assets of the Plan but shall be the property of, and shall be retained by, the University. The University will not be liable for any loss or obligation relating to any insurance coverage except as is expressly provided by this Plan. Such limitation shall include, but not be limited to, losses or obligations that pertain to failure to pay premiums due to non-receipt of premium notices. The University will have no responsibility to maintain any policy in force except as may be specifically required otherwise in this Plan. The University is not liable or responsible for the payment of any premium with respect to periods after participation in the Plan ends (due to termination or otherwise).

7.10 Waiver of Notice. Any notice required under the Plan may be waived by the person entitled to such notice.

7.11 Gender and Number. All personal pronouns hereunder will include either gender, the singular will include the plural, and the plural will include the singular, unless the context clearly indicates otherwise.

7.12 Controlling Law. The Plan will be construed in accordance with ERISA, the Code, and other applicable federal laws and, to the extent not preempted thereby or inconsistent therewith, with the laws of the state of Illinois.

7.13 Interests Not Transferable. Except as otherwise expressly permitted by the Plan or as may be required by the tax withholding provisions of the Code or the income tax laws of any state, benefits under the Plan are not in any way subject to the debts or other obligations of the persons entitled thereto and may not be voluntarily or involuntarily sold, transferred, alienated, assigned or encumbered.

7.14 Facility of Payment. When any person entitled to benefits under the Plan is under legal disability or, in the Plan Administrator's opinion, is in any way incapacitated so as to be unable to manage his or her affairs, the Plan Administrator, in its sole discretion, may cause such

person's benefits to be paid to such person's legal representative for his or her benefit, or to be applied for the benefit of such person in any other manner that the Plan Administrator may determine. The Plan Administrator may take actions including, but not limited to, the following: (i) requiring the appointment of a conservator or guardian for such individual, (ii) distributing amounts to relatives of such individual for the benefit of such individual, or (iii) distributing such amounts directly to or for the benefit of such individual, provided however, that a conservator, guardian, or other person charged with such individual's care has not been appointed. Payment under this Section 7.13 shall constitute a full discharge of liability for such benefits by the University, the Plan Administrator, and the Plan.

7.15 No Vested Interest. Except for his or her right to receive any benefit that has accrued under the Plan, no person has any right, title or interest in or to any contributions made under the Plan, such contributions being made for the sole purpose of providing benefits under the Plan in accordance with its terms. Neither the Employer nor the Plan Administrator will in any way guarantee the payment of any benefit that may be or become due to any person under the Plan.

7.16 Employment Rights. Employment rights of an Employee will not be deemed to be enlarged or diminished by reason of the establishment of the Plan, nor will establishment of the Plan constitute a contract of employment with any Employee or confer upon any Employee any right to be retained in the service of the Employer.

7.17 Evidence. The Plan Administrator may require evidence under the Plan to be signed, and made or presented by the proper party or parties in the form of a certificate, affidavit, document or other medium that the person acting on it considers reliable.

7.18 Physical Examination and Autopsy. The Plan Administrator, at its own expense, may have any individual whose injury, illness, or sickness is the basis of claim under the Plan examined by a physician designated by it, when and as often as it may reasonably require, while a claim is pending under the Plan, and to order an autopsy in the case of death, provided it is not otherwise prohibited by law.

7.19 Recovery of Benefits. In the event a Participant receives a benefit payment under the Plan that is in excess of the benefit payment that should have been made, the Plan Administrator will have the right to recover the amount of such excess from such Participant. The Plan Administrator may, however, at its option, deduct the amount of such excess from any subsequent benefits payable to, or for, the Participant.

7.20 No Waiver of Plan Provisions. Failure of the Employer, the Plan Administrator, or the Claims Administrator to insist upon compliance with any provision of the Plan at any given time or under any given set of circumstances will not operate to waive or modify that provision, or in any manner whatsoever to render it unenforceable, as to any other time or as to any other occurrence, whether the circumstances are, or are not, the same.

7.21 Effect on Workers' Compensation. The Plan is not intended to be and is not in lieu of any Workers' Compensation Act insurance and does not affect any requirement for Workers' Compensation Act insurance coverage.

7.22 Headings. The headings of articles and sections are included solely for convenience of reference, and are not to be used in the interpretation of the provisions of the Plan.

7.23 Successors and Assigns. The Plan shall inure to the benefit of, and be binding upon, the parties hereto and their successors and assigns.

7.24 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or on behalf of any Participant will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. Each Participant shall be obligated to determine whether each payment under the Plan is excludable from his gross income for federal and state income tax purposes, and to notify the Employer if he or she has reason to believe that any such payment is not so excludable.

7.25 Correction of Errors. In the event an incorrect amount is paid to or on behalf of a Participant, Dependent, or, to the extent applicable, Beneficiary, any remaining payments may be adjusted to correct the error except to the extent prohibited by applicable law. The Plan Administrator may take such other action it deems necessary and equitable to correct any such error.

7.26 Invalidity of Certain Provisions. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof and the Plan shall be construed and enforced as if such provisions had not been included.

VIII. AMENDMENT AND TERMINATION

8.1 Amendment. Any part of the Plan may be amended by the University, or such person or entity to whom the University has delegated such authority, at any time or from time to time, by written instrument, and without prior notice (except as required by law). Notwithstanding the foregoing, where a change to or in connection with the Plan documents affects the information described in Exhibit A, then Exhibit A may be updated in accordance with the change without a formal amendment. For example, if a Plan document is amended or replaced with a similar document (e.g., a group insurance contract is replaced by another contract issued by a different insurer), Exhibit A may be replaced, without a formal amendment, with a new Exhibit A reflecting the updated information.

8.2 Termination. The University established this Plan with the intention that it will be maintained indefinitely. However, the Plan may be terminated at any time by action of the University. Claims and expenses incurred prior to the termination will be paid in accordance with the terms of the Plan.

This University of Chicago Group Life and Disability Plan is adopted and approved by its duly authorized officer this 18 day of June, 2019.

THE UNIVERSITY OF CHICAGO

By: _____

Its: Vice President and Chief Financial Officer

UNIVERSITY OF CHICAGO GROUP LIFE AND DISABILITY PLAN

EXHIBIT A
Plan Documents

Sun Life Assurance Company of Canada Policy No. 241961-001

University of Chicago Group Life Insurance Summary Plan Description

University of Chicago Long-Term Disability Summary Plan Description