Summary Plan Description

For the

Ashford University, LLC
Wrap Benefit Plan

Effective as of July 1, 2019

This document together with the Certificates of Coverage or the Component Benefit Plans and other documents identified in this document constitutes the Summary Plan Description.

Ashford University, LLC Wrap Benefit Plan
SUMMARY PLAN DESCRIPTION
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Introduction

Ashford University, LLC (the "Employer") has established the Ashford University, LLC Wrap Benefit Plan (the "Plan"). The Plan's purpose is to combine in one plan document provisions of the health and welfare benefit plans (the "Component Benefit Plans") sponsored by Ashford University, LLC and its affiliated employers (if any), and to provide uniform administration of these health and welfare benefits. The Component Benefit Plans are listed in **Appendix A** to this Summary Plan Description ("SPD"). This SPD reflects and summarizes the terms of the Plan in effect on July 1, 2019. Presently, there are no controlled group entities or affiliated employers of the Employer that have employees participating in the Plan. Participating controlled group entities or affiliated employers may be added or changed from time to time.

The insurance contracts (including Certificates of Coverage), summary plan descriptions, policies and procedures, and any other documents making up the Component Benefit Plans are not affected by the adoption of the Plan, and the terms of the Component Benefit Plans will continue to control for purposes of determining your benefits. (References in this document to insurance contracts, insurance policies and insurance generally will include HMO contracts (if any) or similar arrangements.) The terms of each Component Benefit Plan are incorporated into this SPD by reference and will continue to act as the primary source of information for each Component Benefit Plan. However, if a conflict of language exists between the Component Benefit Plan and the Plan or SPD, the Component Benefit Plan will control as long as the Component Benefit Plan is not inconsistent with Federal law and regulations. The exception is, regardless of a Component Benefit Plan's identification of a Plan Year or Plan Number, the Plan Year or Plan Number of this SPD will control.

Note: Every effort has been made to accurately describe the Plan in this SPD. However, if there should be a discrepancy between the SPD and the Plan document -- or if the Plan is required to operate in a different manner to comply with Federal laws and regulations -- the Plan document or the appropriate Federal laws and regulations will control.

If you have not received a Certificate of Coverage (which also may be known as a certificate of insurance or evidence of coverage) or other document that summarizes in detail a Component Benefit Plan, you may request the Certificate of Coverage or other document which will be made available by the Plan Administrator (identified under the heading "Plan Administrator") to you or your beneficiaries without cost.

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address or email and the addresses of any family members who are covered by the Plan.

General Information Pertaining to the Plan

Plan Name, Sponsor and Employer EIN

The name of the Plan is Ashford University, LLC Wrap Benefit Plan. Ashford University, LLC is the Plan Sponsor. The Employer's address is 8620 Spectrum Center Blvd, San Diego, CA, 92123. The Employer's telephone number is 800-798-0584. The Employer's Federal employer identification number (EIN) is 20-2076985.

Plan Year

For recordkeeping purposes, the Plan Year for the Plan is the 12 month period beginning on July 1 and ending June 30.

Plan Number

The number of this Plan is 501.

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Type of Welfare Benefit Plan(s)

The Plan may provide various welfare benefits under the Component Benefit Plan(s) listed in **Appendix A** to this SPD.

Funding

Benefits under the Plan are funded by one or more of the following methods selected by Ashford University, LLC for a Component Benefit Plan: insured benefits, self-funded benefits (these are benefits funded by general assets of the Employer or through a trust), or a combination of insured benefits, self-funded benefits and trust benefits. For details on the funding status of Component Benefit Plans, see **Appendix A.** Funding for the Plan will consist of the funding for all Component Benefit Plans and may include funding through a cafeteria plan which, if available, is identified as a funding source in **Appendix A.**

Ashford University, LLC has the right to pay benefits from its general assets, insure any benefits under the Plan, and establish any fund or trust for the holding of contributions or payment of benefits under the Plan, either as mandated by law or as Ashford University, LLC determines advisable in its sole discretion. In addition, Ashford University, LLC has the right to alter, modify or terminate any method or methods used to fund the payment of benefits under the Plan, including, but not limited to, any trust or insurance policy. If any benefit or portion of the benefit is funded by the purchase of insurance, the benefit or portion of the benefit will be payable solely by the insurance company.

Plan Administrator

The Plan Administrator is Ashford University, LLC, 8620 Spectrum Center Blvd, San Diego, CA, 92123, telephone number 800-798-0584, which, for insured benefits offered through the Plan, administers the Component Benefit Plans with the insurance companies providing benefits under the Component Benefit Plans as named fiduciaries. The insurance companies shown in **Appendix A** are responsible for considering, accepting or denying, and paying claims for the insured benefits. The indicated insurance company is responsible for considering any appeals to the insured benefits made following a Component Benefit Plan's claim procedures and, if applicable, the claim procedures indicated in this SPD. Any third-party administrator ("TPA") responsible for administering a Component Benefit Plan not funded through insurance may be listed in **Appendix A**. Therefore, the Plan Sponsor is the administrator of the Component Benefit Plan, unless otherwise specified in **Appendix A**, which identifies the administrator as the "Sponsor" or the "Insurer" or the "Contract Administrator." In addition, if a party has accepted named fiduciary status in considering, accepting or denying, and paying claims (including any appeals relating to such claims), that party (also referred to as a "Claim Fiduciary") is identified in **Appendix A**.

Agent for Service of Legal Process

The agent for service of legal process is Ashford University, LLC, 8620 Spectrum Center Blvd, San Diego, CA, 92123. Service may also be made on the Plan Administrator.

Named Fiduciary

The Plan Administrator is the primary named fiduciary of the Plan and has the exclusive and express discretionary authority to interpret the terms of the Plan and the terms of all the Component Benefit Plans to the extent not delegated to another named fiduciary. For insured Component Benefit Plans, the insurance company is also a named fiduciary under the Plan as to the determination of the amount of, and entitlement to, insured benefits with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the insurance policy. In addition, where any other party has accepted status as a named fiduciary, with respect to the determination of the amount of, and entitlement to, benefits under any uninsured Component Benefit Plan, such named fiduciary (also referred to as the Claim Fiduciary) with respect to the applicable

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Component Benefit Plan is identified in **Appendix A**.

Insurance Company Refund

As to any insurance company refund/rebate received by Ashford University, LLC that is subject to the Medical Loss Ratio ("MLR") provisions of the Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act" or "ACA") and the further guidance provided by Department of Labor Technical Release 2011-04, the Plan Administrator will determine what portion (if any) of such rebate must be treated as "plan assets" under ERISA (note that MLR provisions do not apply to self-funded plans). If any portion of the rebate must be treated as "plan assets," the Plan Administrator will determine, in its sole discretion, the manner in which such amounts will be used by the Plan or applied to the benefit of the Participants (the Participants need not be the same as those who made contributions under the policy that issued the rebate). Any portion of the rebate that is not treated as a 'plan asset' will be allocated to any employer or, if applicable, among one or more employer(s) as the Plan Sponsor in its sole discretion determines appropriate. If the rebate is applied toward a benefit enhancement or as an offset to participants' share of future premiums, verification of the additional benefit or how the premium offset will be applied (e.g., will there be a one-time premium holiday, or will the participants' share of premiums be reduced over a period of months) should be provided in a written policy.

Plan Document

The Plan and those documents incorporated by reference in the Plan compose a written employee benefit welfare plan as defined by ERISA.

Coverage for Spouses, Dependents, and/or Domestic Partners

One or more Component Benefit Plans covered under the Plan may identify spouses, dependents/children, domestic partners and others as eligible non-employee participants on **Appendix A**. The provisions relating to that coverage should be detailed in the Certificates of Coverage or other Component Benefit Plan documents. Note that you have an obligation to notify the Employer promptly of any loss of dependent status.

If you want to enroll your domestic partner, you should ask at the time of enrollment elections what information is necessary to apply, including any affidavit and/or other documentation required by the Plan Administrator. Contact the Plan Administrator if you have questions.

No Guarantee of Non-Taxability

The Plan provides benefits often intended to be non-taxable. The Plan Administrator or any fiduciary or party associated with the Plan will not be in any way liable for any taxes or any other liability incurred by you or any person claiming through you.

No Guarantee of Employment

The offering of the Component Benefit Plans under the Plan is not a commitment or guarantee of employment by any Employer and does not affect any Employer's rights to discharge any employee.

Nondiscrimination

Contributions and benefits under the Plan will not discriminate in favor of "highly compensated employees" or "key employees" as such terms are defined under the Code. The Employer may limit or deny your compensation reduction agreement to the extent necessary to avoid such discrimination in compliance with federal law.

Anti-Assignment

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan and any attempt to do so will be void. The payment of benefits directly to a health care provider, if any, shall be done as a convenience to the

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participant and shall not constitute an assignment of benefits under the Plan.

Eligibility, Participation and Benefits

Eligibility and Participation

Eligibility for participation and benefits under the Plan is determined under the written terms of the Plan and each Component Benefit Plan. See a summary of more information regarding eligibility and participation in **Appendix A**.

If you previously participated in the Plan and are rehired, you will be eligible to become a Participant on the same terms as if you were a newly hired employee. However, in most instances, group health plans offered by an "applicable large employer" (generally, an employer that employs an average of at least 50 full-time employees (including full-time equivalent employees)) are subject to the Affordable Care Act and have special rehire rules. These rules are as follows: if your Employer is subject to the ACA and you return to work after a period during which you were not credited with any hours of service, you may be treated as having terminated employment and been rehired as a new Employee only if the following conditions apply: (i) you had no hours of service for a period of at least 13 consecutive weeks (26 for educational organization employers); or (ii) you had a break in service of a shorter period of at least four consecutive weeks with no credited hours of service, and that period exceeded the number of weeks of your period of employment. These provisions are intended to comply with the ACA and are not intended to expand the rights or benefits of employees for any other purpose and should be so construed.

If your Employer believes it is an "applicable large employer" under the ACA, it may elect to take advantage of the look-back provisions of the ACA. See **Appendix B** for details.

Insurance carriers sometimes impose an "actively at work" requirement for certain types of insurance (for example, life and disability). Therefore, your participation in those benefits may be delayed or otherwise affected. This requirement would be reflected in your Certificate of Coverage. This may also be the case in which you are rehired as an employee.

Note that the "actively at work" requirement does not apply to a Group Health Plan (other than one offering only HIPAA-excepted coverage) unless there is an exception for individuals who are absent from work due to a health factor (e.g., individual is out on sick leave on the day the coverage would otherwise become effective).

As to any Component Benefit Plan that is a group health plan (other than one offering only HIPAA-excepted coverage), any otherwise eligible employee must wait no longer than ninety (90) days to begin coverage under such Component Benefit Plan.

Contributions

The cost of the benefits provided through the Component Benefit Plans may be funded in part by Employer contributions and in part by your contributions. In some instances, a Component Benefit Plan may require only you or Ashford University, LLC to contribute. If specified in **Appendix A,** the cost of benefits provided through a Component Benefit Plan may be funded pre-tax through a cafeteria plan under Section 125 of the Internal Revenue Code. The sources of Plan contributions are listed in **Appendix A**. Ashford University, LLC will determine and periodically communicate your share of the cost of the benefits provided through each Component Benefit Plan, and it may change that determination at any time. Ashford University, LLC will make any Employer's contributions in an amount that in the Employer's sole discretion is at least sufficient to fund the benefits or a portion of

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the benefits that are not otherwise funded by your contributions. Ashford University, LLC will pay its contribution and your contributions to an insurance company or, for benefits that are self-funded, will use these contributions to pay benefits directly to or on behalf of you or your eligible family members. Your contributions will be used in their entirety prior to using Employer contributions to pay for the cost of that benefit. Where relevant to a Component Benefit Plan, you will receive during the open enrollment period notice of the amount for which you are responsible. If your cost for a Component Benefit Plan is adjusted during the Plan Year, you will be notified of that adjustment unless the Component Benefit Plan provides otherwise.

The Plan Administrator will have the right to recover any payment it made but should not have made or made to an individual or organization not entitled to payment, from the individual, organization or anyone else benefiting from the improper payment.

Benefits Available

The benefits available under the Plan consist of the benefits available under the Component Benefit Plans, including all limitations and exclusions for each Component Benefit Plan's benefits. The benefits available under each Component Benefit Plan are set forth in the Component Benefit Plan documents. The availability of benefits is subject to your payment of all applicable contributions and satisfaction of any eligibility or other requirements of a particular Component Benefit Plan.

Any health care flexible spending account under a cafeteria plan will be subject to this Plan and the requirements of ERISA. Nonetheless, a premium or premium equivalent (i.e., the cost of coverage) reduction portion of a cafeteria plan (and any dependent care assistance plan offered under the cafeteria plan) will not be subject to the requirements of ERISA, even though the cafeteria plan (and any dependent care assistance plan) may be considered part of the Plan.

Where a health benefit involves the use of "network providers" (also sometimes referred to as "PPO", "EPO" or "preferred providers"), you will receive listings of such providers without charge. The listings may be provided in one or more separate documents or by electronic document access via the Internet.

Where a network is involved, a benefit document will include provisions governing the use of such providers, primary care providers or providers of specialty services, the composition of the network and whether and under what circumstances coverage is provided for emergency and out-of-network services.

Loss of Benefits

Your benefits (and the benefits of your eligible dependents) generally will cease when your participation in the Plan terminates. Benefits will also cease upon termination of the Plan. Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. The insurance contracts (including the Certificates of Coverage), plans, and other governing documents of the Component Benefit Plans provide additional information. The subrogation provisions of the Plan are discussed in more detail in the section "Employer's Right of Reimbursement."

Benefit Elections

Electing Your Benefits for the Plan Year Under a Component Benefit Plan

Some of the Component Benefit Plans may require you to make an annual election to enroll for coverage for the next plan year prior to the beginning of that year. The plan year for each Component Benefit Plan should be set forth in that plan and may be different than the Plan Year for this Plan. Thus, the discussion below regarding plan year refers to the relevant Component Benefit Plan's plan year.

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If you first become eligible to participate in a Component Benefit Plan during a plan year in progress, your initial elections pertain to the remaining part of that plan year. Then, before each new plan year begins, you will have an opportunity to change or cancel your elections during the annual open enrollment period. The annual open enrollment period is described below.

Making Your Elections

In making your elections, you may elect and enroll for some or all of the benefits available under a Component Benefit Plan. You may also elect not to participate in a Component Benefit Plan for which annual elections are then being made.

Benefits are elected by completing and submitting an election form in a format approved by the Plan Administrator (whether in paper or electronic format) before the end of the annual open enrollment period. When you make your elections, you also authorize the necessary payroll deductions for paying your part of the cost of the benefits you elect.

Once you are a participant in the Plan, if you become eligible for additional benefits during a plan year, you will be given an opportunity to elect and enroll in the benefits for which you are newly eligible.

Annual Election Period

Before the beginning of each plan year, Ashford University, LLC often may hold an annual open enrollment period. In that case, Ashford University, LLC will notify you when the dates for the annual open enrollment period will occur each year. During this time, you may make new elections for the upcoming plan year. Your elections from the prior year may roll forward to the current year. You should consult with material provided to you during the annual open enrollment period to determine whether an election is required.

Changing Your Elections during a Plan Year

Where a Component Benefit Plan is funded through a cafeteria plan, once you have made your elections for a plan year, it pertains to the entire plan year as it applies to that Component Benefit Plan and cannot be changed or cancelled during that time except in certain limited situations that are described in the cafeteria plan. Other election restrictions may apply to Component Benefit Plans. For example, if you elect not to participate in the health plan when first eligible, you may need to wait until an open enrollment period as specified in the Component Benefit Plan.

If you, your spouse, or your dependent child experience a "change in status," and that change in status makes you, your spouse, or your dependent child eligible or ineligible for any of the pre-tax benefits, or for any of the benefit options sponsored by your spouse's or your eligible dependent child's employer, you may change the amount of your election in a way that is consistent with that "change in status," provided you notify the Plan Administrator of such change within 30 days (or, for some employers, 31 days) of such change. The determination of whether you have experienced an event that would permit an election change and whether your requested election change is consistent with such an event shall be made in the sole discretion of the Plan Administrator.

These rules also apply to a spouse and other individuals such as a domestic partner under certain circumstances.

A "change in status" includes a change in the following:

(a) marriage;

(b) other changes in your legal marital status (for example, your divorce, annulment, or legal separation, or the death of your spouse);

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(c) birth or adoption of a child, including placement for adoption;

(d) other changes in the number of your dependents (for example, legal guardianship for a child);

(e) you, your spouse's or your dependent child's employment status (for example, terminating or beginning a job; changing the number of hours worked, such as switching from full-time to part-time, or vice versa);

(f) you, your spouse or your dependent child begins or returns from certain types of unpaid leave of absence (FMLA or USERRA) or change in worksite;

(g) your dependent satisfies or ceases to satisfy eligibility requirements (for example, attainment of the limiting age, loss of student status, or similar circumstances);

(h) your (or your spouse's or dependent's) residence that results in gaining or losing eligibility for a health care option (such as moving out of an HMO service area); and

(i) any other event specified under the Employer's cafeteria plan that is consistent with IRS regulations and pronouncements, such as the specific situations related to the availability of coverage through a Health Insurance Exchange (or Marketplace) as provided in IRS Notice 2014-55, which allows prospective revocation of the employee's election under certain circumstances.

Claims Procedures

Benefits Administered by Insurers and TPAs

Claims for benefits that are insured or administered by a TPA must be filed in accordance with the specific procedures contained in the insurance policies, Component Benefit Plans or the third party administrative services agreement. These procedures will be followed unless inconsistent with the requirements of ERISA as specified in more detail below. The name (and in the case of group health plan claims, the address) of the individual insurance company providing benefits and reviewing claims relating to its insurance policy is set forth in **Appendix A**. Further, the name and address of the TPA (if any) that reviews claims made under a Component Benefit Plan may be set forth in **Appendix A**. All other general claims or requests should be directed to the Plan Administrator.

Personal Representative

You may exercise your rights directly or through an authorized personal representative. You may only have one representative at a time to assist in submitting an individual claim or appealing an unfavorable claim determination.

Your personal representative will be required to produce evidence of his or her authority to act on your behalf. The Plan may require you to execute a form relating to the representative's authority before that person will be given access to your protected health information or allowed to take any action for you. (A mere assignment or attempted assignment of your benefits does not constitute a designation of an authorized personal representative. Such a delegation must be clearly stated in a form acceptable to the Plan.) This authority may be proved by one of the following:

(a) A power of attorney for health care purposes, notarized by a notary public;

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(b) A court order of appointment of the person as the conservator or guardian of the individual; or

(c) An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your protected health information to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

General Claims Procedure

If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (discussed under the heading Claims Procedure), you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

The Plan's claims procedures are described below. (These claims procedures do not apply to any cafeteria plan which is a premium-only plan ("POP") or to any dependent care assistance plan offered.)

The following procedures will be followed for denied claims under a Component Benefit Plan that is not a group health plan or disability plan. For group health claims and disability claims, see headings "Special Rules for Group Health Plan Claims" and "Special Rules for Disability Claims."

(a) If your claim is denied, you or your beneficiary will receive written notification within 90 days after your claim was submitted. Under special circumstances, the Claim Fiduciary may take up to an additional 90 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 before the end of the initial 90-day period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. The written notification of a denied claim for benefits will include the reasons for the denial, with reference to the specific provisions of the Component Benefit Plan on which the denial was based, a description of any additional information needed to process the claim, and an explanation of the claims review procedure. If you do not receive a response within 90 days, your claim is treated as denied.

(b) Within 60 days after notification of a claim denial, you may appeal the denial by submitting a written request for reconsideration of the claim to the Plan Administrator or its delegate such as the insurance company or TPA, which includes the reasons why you feel the claim is valid and the reasons why you think the claim should not be denied. Before submitting an appeal request, you may request to examine and receive copies of all documents, records, and other information relevant to the claim. If you fail to file an appeal for review within 60 days of the denial notification, the claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it under these procedures or in a court or any other venue. Documents, records, written comments, and other information in support of your appeal should accompany any appeal request. The Plan Administrator or its delegate will consider such information in reviewing the claim and provide, within 60 days, a written response to the appeal. This 60-day period may be extended an additional 60 days under special circumstances, as determined by the Plan Administrator or its delegate due to matters beyond its control. If an extension of time is required, you will be notified before the end of the initial 60-day period of the circumstances requiring the

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extension and the date by which the Plan Administrator or its delegate expects to render a decision. The Plan Administrator's response (or its delegate's) will explain the reason for the decision with specific reference to the provisions of the Plan on which the decision is based, 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 and a statement about your right to bring a civil action under ERISA Section 502(a).

(c) The Plan Administrator or its delegate has the sole discretion to interpret the appropriate Plan provisions, and such decisions are conclusive and binding.

(d) To the extent not inconsistent with the provisions of the applicable Component Benefit Plan, with respect to any civil action brought under the Plan, a claimant will be barred from bringing such civil action after one year from the date of exhausting the Plan's claims procedures relating to the denial of the claim. In the case of a group health plan claim discussed below, this includes not only exhausting the Plan's internal claims procedure but also exhausting the Plan's external claims procedure, where applicable.

Special Rules for Group Health Plan Claims

For purposes of ERISA, there are four categories of claims under a Component Benefit Plan that is a group health plan (e.g., medical, dental, vision, health care flexible spending account and EAP benefits), and each one has a specific timetable for approval, request for additional information, or denial of the claim. The four categories of claims are:

Urgent Care Claims - a claim where failing to make a determination quickly could seriously jeopardize a claimant's life, health, or ability to regain maximum function, or could subject the claimant to severe pain that could not be managed without the requested treatment. A licensed physician with knowledge of the claimant's medical condition or an insurance company or TPA (applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine) may determine if a claim is an Urgent Care Claim.

Pre-Service Claims - a claim for which you are required to get advance approval or pre-certification before obtaining service or treatment for the medical services.

Post-Service Claims - a request for payment for covered services you have already received.

Concurrent Care Claims – a request to extend an ongoing course of treatment beyond the period of time or number of treatments that has previously been approved under the Plan.

(a) Time for Decision on a Claim. The time deadline for making decisions on claims under the Plan depends on the category of the claim. (See Time Limit Chart below for maximum time limits.) You will be notified of any determination on your claim (whether favorable or unfavorable) as soon as possible. If an Urgent Care Claim is denied, you will be notified orally and written notice will be provided to you within three days.

Note that fully-insured plan claims (if any) may be subject to an even more accelerated response time by the insurance company handling the claim. See Certificates of Coverage for details.

If additional information is needed because necessary information is missing from the initial claim request, a notice requesting the missing information from you will be sent within the timeframes shown in the chart below and will specify what information is needed. You must provide the specified information to the Claim Fiduciary within 45 days after receiving the notice. The determination period will be suspended on the date the Claim Fiduciary sends a notice

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of missing information and the determination period will resume on the date you respond to the notice.

Under special circumstances with respect to pre-service and post-service claims, the Claim Fiduciary may take up to an additional 15 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 before the end of the initial claim determination time period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. The notice of extension that you receive will include (i) an explanation of the standards on which entitlement to benefits is based; (ii) the unresolved issues that prevent a decision on the claim; and (iii) any additional information needed to resolve those issues.

(b) Notification of Denial. Except for Urgent Care Claims, when notification may be oral followed by written notice within three days, you will receive written notice if your claim is denied. The notice will contain the following information:

(1) the specific reason or reasons for the adverse determination;

(2) reference to the specific Plan provisions on which the determination was made;

(3) a description of any additional material or information necessary to perfect your claim and an explanation of why this material or information is necessary;

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

(5) 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;

(6) if an adverse determination is based on an internal rule, guidance, protocol, or other similar criteria, an explanation of those criteria or a statement that the criteria will be provided to you free of charge upon request; and

(7) if the adverse determination is based on a medical necessity or experimental treatment limit or exclusion, an explanation of the scientific or clinical judgment on which such decision is based, 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. The Plan fiduciary will provide an independent full and fair review of your claim and will not give any deference or weight to the initial adverse determination. You will receive a written notice of the decision on review.

(c) How to Appeal a Denied Group Health Plan Claim. If your claim is denied, you (or your attorney or other person authorized by you in writing to act on your behalf) will have 180 days following the date you receive written notice of the denial in which to appeal such denial. If you fail to file an appeal for review within 180 days of the denial notification, the claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it under these procedures or in a court or any other venue. Unless you are appealing the denial of an Urgent Care Claim, your request for review should be made in writing. If you are requesting review of an Urgent Care Claim, you may request review orally or by facsimile. A request for review must contain your name

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and address, the date you received notice your claim was denied, and your reason(s) for disputing the denial. You may submit written comments, documents, records, and other information relating to your claim. If you request, you will be provided, free of charge, reasonable access to, or copies of, all documents, records, and other information relevant to the claim.

The period of time for the Plan to review your appeal request and to notify you of its decision depends on the type of claim as follows:

Urgent Care Claim – 72 hours; you will be notified orally and written notice will be provided within three days.

Pre-Service Claim – 30 days if the Component Benefit Plan provides for only one mandatory appeal; 15 days for each appeal if the Component Benefit Plan provides for two mandatory appeals.

Post-Service Claim – 60 days if the Component Benefit Plan provides for only one mandatory appeal; 30 days for each appeal if the Component Benefit Plan provides for two mandatory appeals.

The review will take into account all comments, documents, records, and other information you submit relating to your claim, without regard to whether that information was submitted or considered in the initial claim determination. The review will be conducted by a Plan fiduciary other than the person or persons (or subordinate of such person or persons) who conducted the initial claim determination. In addition, if the denial of the claim was based, in whole or in part, on a medical judgment in reviewing the claim, the Claim Fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment in reviewing the claim. This person will not be a person or a subordinate of a person consulted by the Claim Fiduciary in deciding the initial claim. The Plan fiduciary will provide an independent full and fair review of your claim and will not give any deference or weight to the initial adverse determination. You will receive a written notice of the decision on review. The notice will contain the following information:

(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

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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."

Also, upon request, the Claim Fiduciary will provide you with a statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.

Time Limit (Group Health Plan Claims)	Urgent Care*	Pre-Service*	Post-Service*
To make initial claim determination	72 hours	15 days	30 days
Extension (with proper notice and if delay is due to matters beyond Plan's control)	None	15 days	15 days
To request missing information from claimant	24 hours	5 days	30 days
For claimant to provide missing information	48 hours	45 days	45 days

* The Claim Fiduciary will decide the appeal of "Concurrent Care Claims" within the time frame set forth above depending on whether that claim is also an Urgent Care Claim and the request to extend care is not made at least 24 hours prior to the scheduled expiration of treatment, a Pre-Service Claim, or a Post-Service Claim and before the expiration of any previously approved course of treatment. For an Urgent Care Claim that is a Concurrent Care Claim, if the request to extend care is made at least 24 hours prior to the scheduled expiration of the treatment, the initial claim determination will be made no later than 24 hours after such claim is filed with the Claim Fiduciary.

Special Internal Appeals Review Procedures Under the Affordable Care Act

Under the ACA, the following internal claims provisions apply to any "non-grandfathered," non-HIPAA-excepted coverage of the Plan based upon, generally whether the Plan is (1) fully-insured or (2) self-funded *for any "Adverse Benefit Determination" (i.e., any medical claim or any claim involving a rescission of coverage)*.

(a) A rescission is allowed only upon a finding of fraud or intentional misrepresentation of a material fact;

(b) You must be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. It must also provide you with any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for you to respond to the new evidence or rationale;

(c) Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual by a claims adjudicator or medical expert may not be based on the likelihood that that person will support the denial of benefits due to that influence (this prohibition is to avoid conflicts of interest);

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(d) Notices to claimants by the Plan or Claim Fiduciary must also include additional content as follows:

(1) Any notice of Adverse Benefit Determination or final internal Adverse Benefit Determination must include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable) and state that, upon your request, the diagnosis code and treatment code and their corresponding meanings will be provided as soon as practicable.

(2) Any notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination must include the denial code and corresponding meaning as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a final internal Adverse Benefit Determination, this description must also include a discussion of the decision.

(3) A description of available internal appeals and external review processes, including information about how to initiate an appeal.

(4) The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman.

(5) Notices of any Adverse Benefit Determination must be in a culturally and linguistically appropriate manner, consistent with the DOL regulations, to any claimant in the health plan who resides in a county in which ten percent or more of the population is literate only in the same non-English language as determined by guidance published by the DOL (a "10 Percent Non-English County"). For a health plan that has a claimant in a 10 Percent Non-English County, notices regarding the internal and external claims review must appear in both English and in that other relevant non-English language and, once a request has been made by a claimant, all subsequent notices to such person must be in the applicable non-English language as well. Also, the Plan or Claim Fiduciary must maintain oral language services in the non-English language (such as a telephone customer assistance hotline) to answer questions or provide assistance with filing claims and appeals.

(e) Generally, the Plan's or Claim Fiduciary's failure to adhere to the requirements of the ACA will allow you to deem the internal claims and appeals process "not in compliance" under the ACA, therefore declaring your claim procedure "exhausted." At this point, you may proceed to pursue any external review process or remedies available under ERISA or under State law, if applicable.

You may appeal this determination by requesting external review described in more detail, below.

Special State External Appeals Review Process Under the Affordable Care Act

You should be aware that the Department of Labor ("DOL") has given States a number of options to implement protections included in the external review process for any Adverse Benefit Determination that involves medical judgment (including, but not limited to, a determination regarding medical necessity, appropriateness, health

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care setting, level of care or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational) or any claim involving a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at this time), relating to *insured health benefits* (and certain self-funded arrangements which have been allowed by State law to be subject to the State's review rules). Please refer to the external appeals table identified here: https://www.cms.gov/CCIIO/Resources/Files/external_appeals.html.

(a) A State may meet the "strict standards" included in the DOL rules, which set forth 16 minimum consumer protections;

(b) A State may operate an external review process under "similar standards to those outlined in the July 2010" interim final rule (These "similar standards" apply until January 1, 2018); or

(c) Where the State meets the "strict standards" or the "similar standards," your health plan is subject to the external review procedures reflected in the underlying Certificates of Coverage or to a separate claims document to be provided to you by the insurance company or the Plan.

Special Federal External Appeals Review Process Under the Affordable Care Act

Generally, Plans that are either *self-funded* (are not provided through insured health benefits) or *have not elected or are not eligible to qualify for the State review external appeals process* for any Adverse Benefit Determination are subject to Federal review process described below.

(a) You will have four months after the day you receive notice or are deemed notified of the final internal Adverse Benefit Determination to request an external review of any final internal Adverse Benefit Determination.

(b) The Plan or Claim Fiduciary has five business days from the date a claim is made to complete a preliminary review to determine if the claim is eligible for external review (determining whether you were covered (eligible) at the time the service was provided), whether the appeal relates to a medical judgment, and whether the internal appeals process has been exhausted (e.g., all relevant information requested from the claimant was provided) and, therefore, considered fully.

(c) Within one business day after the preliminary review, the Plan or Claim Fiduciary will notify you in writing of its decision. If the claim is complete but not eligible for external review, you will be provided with the reason for its ineligibility and as well as contact information for the Employee Benefits Security Administration. If the claim is incomplete, you will be provided with an explanation of what is necessary to complete the claim and the Plan Administrator or Claim Fiduciary must give you a reasonable time to complete the claim (i.e., the remainder of the four month appeal period or, if later, 48 hours after the notice of incompletion).

(d) If you appeal an appealable final internal adverse benefits determination (or challenge whether or not it is appealable), your claim must be referred to an Independent Review Organization (IRO) accredited by URAC (formerly known as the Utilization Review Accreditation Commission) or by a similar nationally-recognized accrediting organization to conduct external reviews. The referral will occur through an unbiased selection process involving several IROs.

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(e) Once assigned to the IRO, the IRO must make a determination on a non-Urgent Care Claim within forty-five (45) days after the IRO receives the assignment.

(f) If the IRO reverses the decision of the Plan or Claims Administrator, your payments or coverage must begin immediately, even if the Plan or Claims Administrator expects to appeal it to a court of law.

(g) You must also have a right to expedited review for an Urgent Care Claim upon request. Once assigned to the IRO, the IRO must make a determination as expeditiously as possible but in no event more than seventy-two hours (or forty-eight hours if the request was not in writing) after its receipt of the request. If the IRO's notice of its determination is not provided in writing within 48 hours after the date of providing that notice it must provide written confirmation to you and the Plan.

(h) The contracts with the IROs must include the requirements contained in the DOL Technical Releases, and the IROs must agree, among other things, to the following: de novo review of all information and documents timely received (including the Plan document, claims records, health care professional recommendations, and clinical review criteria used, if any), retaining its records for six years and making them available to the applicable claimant (or to State and Federal government agencies, to the extent not in violation of any privacy laws) for examination upon request, and inclusion of certain information in notices to claimants.

The Plan intends and is taking steps in good faith to comply with the claims and appeals rules under the ACA and the provisions herein should be interpreted accordingly.

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 is denied, the claimant will receive written notice of denial that sets out the information below in an easy to understand

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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 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 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

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expects to render a decision. You have at least 45 days to provide the specified information.

Notification of Benefit Determination on Review

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 charge 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

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

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benefits. Before a decision on review of a denied claim for disability benefits 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 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.

Coverage While on Leave of Absence

Certain Federal laws only apply based on factors such as the number of employees or Participants relating to an Employer's control group or for other reasons. In this regard, the following laws may be applicable. The provisions specified below are intended to reflect the requirements of such laws and are not intended to grant additional rights beyond such laws to any individual, and such language should be interpreted accordingly.

Family and Medical Leave Act Coverage

The Family and Medical Leave Act ("FMLA") of 1993 generally applies to employers with 50 or more employees within a 75 mile radius. FMLA also requires you to have worked a certain number of hours and months in order to be eligible. If you have questions about whether or how FMLA applies to you, you should contact the Plan Administrator for more details. Where applicable it provides certain rights and options relating to your health plan coverage. Generally, this law requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees. This family leave is allowed for the following reasons: incapacity due to pregnancy, prenatal medical care, or child birth; care for the employee's child after birth or placement for adoption or foster care; care for the employee's spouse, child or parent who has a serious health condition; or a serious health condition that makes the employee unable to perform the employee's job.

FMLA was expanded for an eligible employee's parents or immediate family members being called to active military duty status or in active military duty in the following ways: (1) the events for triggering family leave now include "qualifying exigencies" of covered service members. (See your Employer for details.) and (2) eligible employees can take up to 26 weeks of job-protected leave in a single 12-month period care for covered service members with a serious injury or illness.

If you are eligible and choose to take FMLA leave, your Employer must maintain your health coverage under any "group health plan" on the same terms as if you had continued to work. Any changes to the group health plan during the time you are

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on FMLA leave apply to you. Your Employer must also provide you with notice of any opportunity to change plans or benefits during your FMLA leave period.

Depending on your payment of plan premiums, you may be required to continue to pay premiums during FMLA leave. If you are 30 or more days late in making payment and your employer has given you written notice at least 15 days in advance advising that coverage will cease if payment is not received, you will no longer be covered, but upon your return to employment, the employer is required to restore your coverage. However, if you take FMLA leave and do not return to work after leave for a reason other than medical necessity, then you may be required to reimburse your employer for the payments made for your coverage during your leave.

You have the right to choose not to retain health coverage during FMLA leave. Upon return from FMLA leave, most employees must still be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefits that accrued prior to the start of your leave. In addition, your Employer cannot require you to meet any qualification requirements imposed by the plan, including new waiting periods or passing a medical exam to be reinstated.

If you do not return from leave, the 30-day period to request special enrollment in another plan will not start before your FMLA leave ends. Therefore, if you apply for other health coverage, you should tell your plan administrator or health insurer about any prior FMLA leave.

Coverage provided under FMLA is not COBRA coverage, and FMLA leave is not a qualifying event under COBRA. A COBRA qualifying event may occur, however, when an Employer's obligation to maintain health benefits under FMLA ceases, such as if you notify the Employer of your intent not to return to work.

Military Service Leave (USERRA Coverage)

Any participant covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") will continue to participate and be eligible to receive benefits under any Component Benefit Plan that is a group health plan in accordance with USERRA rules and regulations.

Group health plans and health insurance issuers, under USERRA, must protect all persons who perform duty, voluntarily or involuntarily, in the "uniformed services", which include the Army, Navy, Marine Corps, Air Force, Coast Guard and Public Health Service commissioned corps, as well as the reserve components of each of these services. If you are a pre-service member returning from a period of service in the uniformed services, you are entitled to reemployment from your Employer if you meet the following criteria:

(a) you held the job prior to service;

(b) you gave notice to your Employer that you were leaving your employment for service in the uniformed services, unless giving notice was precluded by military necessity or otherwise impossible or unreasonable;

(c) your cumulative period of service did not exceed five years;

(d) you were not released from service under dishonorable or other punitive conditions; and

(e) you reported back to the job in a timely manner or submitted a timely application for reemployment.

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The time limits for returning to work are as follows:

(a) for less than 31 days of service – by the beginning of the first regularly scheduled work period after the end of the calendar day of duty, plus time required to return home safely and an eight hour rest period. If this is impossible or unreasonable through no fault of your own, then as soon as possible;

(b) for 31 to 180 day of service – you must apply for reemployment no later than 14 days after completion of military service. If this is impossible or unreasonable through no fault of your own, then as soon as possible;

(c) for 181 days or more of service – you must apply for reemployment no later than 90 days after completion of military service;

(d) for service-connected injury or illness – reporting or application deadlines are extended for up to two years if you are hospitalized or convalescing.

If you were covered under a Component Benefit Plan which is a group health plan immediately prior to taking a leave for service in the uniformed services, you may elect to continue your coverage under USERRA for certain periods required under USERRA, if you pay any required contributions toward the cost of your group health plan coverage during the leave. Any USERRA continuation coverage you elect will end earlier if one of the following events takes place:

(a) You fail to make a premium payment (or premium equivalent) within the required time;

(b) You fail to report to work or to apply for reemployment within the time period required by USERRA following the completion of your service; or

(c) You lose your rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or fewer, your contribution amount will be the same as for active employees, as long as you remain an active employee. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage described below under the section entitled "Other Continuation/Conversion Privileges." If you elect USERRA coverage, you may not elect COBRA coverage during your military service. Likewise, if you elect COBRA continuation coverage during your military service, you may not elect USERRA coverage when your COBRA coverage ends.

If your coverage under the Plan terminated because of your service in the uniformed services, your coverage will be reinstated on the first day you return to employment if you are released under honorable conditions and you return to employment within the time period required by USERRA. See the Plan Administrator for details.

Certain Federal Rights of Individuals Under Health Plans

Certain Federal laws only apply based on factors such as the number of employees or Participants relating to an Employer's control group or for other reasons. In this regard, the following laws may be applicable. The provisions specified below are intended to reflect the requirements of such laws and are not intended to grant additional rights beyond such laws to any

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individual, and such language should be interpreted accordingly.

Benefits for Adopted Children

If the group health plan under which you are covered provides benefits for dependent children, Ashford University, LLC group health plan will extend benefits to dependent children placed with a participant for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants.

Children's Health Insurance Program Reconciliation Act

The Children's Health Insurance Program ("CHIP") was created to provide affordable health coverage to certain individuals and their dependents who are not eligible for Medicaid yet cannot get private coverage. In the case of group health plans, various amendments to CHIP allow States to subsidize premiums for employer-provided group health coverage for eligible employees and their dependents. Each State in which an employee resides will choose whether it will implement this optional subsidy. CHIP also allows for a special enrollment period under group health plans in case of termination of Medicaid or CHIP coverage.

Generally, if you are eligible, you may be able to enroll in the employer's group health plan within 60 days of losing coverage under the Medicaid or CHIP plan or within 60 days of becoming eligible for premium assistance under the Medicaid or CHIP plan. Find out if your State has CHIP and/or Medicaid available, and speak with your Plan Administrator for further details.

COBRA Rights

Employers who employ 20 or more employees are subject to the group health plan continuation provisions of Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Generally, where COBRA applies, if you or your eligible family members' group health plan coverage ceases because of certain "qualifying events" specified in COBRA (such as termination of employment for reasons other than gross misconduct, reduction in hours, divorce, death, or a child's ceasing to meet the definition of dependent), then you or your eligible family members may have the right to purchase continuation coverage for a temporary period of time. You may also have coverage continuation rights under State insurance laws, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. Information on State insurance law continuations is contained in the Certificate of Coverage (or its equivalent) which is incorporated by reference in **Appendix A**. As an additional benefit, the Employer may extend to civil union partners, and qualified same-sex domestic partners the rights which may parallel the Federal laws of COBRA ("COBRA-like rights"). It should be noted that any COBRA-like rights offered by an employer presently do not enjoy the same income tax benefits at the Federal level and may not at the State level. This document does not address Federal, State and local tax treatment in detail, and is not intended to provide tax advice. For information on how applicable tax laws may apply to your personal situation, consult your tax adviser. See applicable Certificate of Coverage (or its equivalent) as well as the Plan Administrator (or third-party COBRA administrator, if any) for details.

If you, your spouse, or your dependents lose coverage under the Plan because you experience a life event known as a "qualifying event," you and/or your spouse and dependents may be eligible to elect continuation coverage under COBRA for the portions of the Plan that are a "group health plan" (e.g., medical, dental, vision,

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health reimbursement arrangement, telemedicine, expert medical opinion (in some cases) and health care flexible spending account ("health care FSA") benefits).

You, your spouse, or your dependents experience a "qualifying event" under COBRA if your employment terminates (or your hours are reduced making you ineligible for participation) for reasons other than gross misconduct. Additionally, your spouse or your dependents may experience a "qualifying event" due to your divorce, legal separation, death, or entitlement to Medicare. If you (or your spouse or your dependents) experience one of these qualifying events, and as a result lose coverage under the Plan, you (or your spouse or your dependents) may be eligible for COBRA.

To be eligible for COBRA in the event of a divorce or legal separation, or if your dependents become ineligible under the Plan, you, your spouse, and/or your dependents must notify the Plan Administrator (or third-party COBRA administrator, if any) as soon as possible after the qualifying event occurs, and no later than 60 days after the qualifying event occurs. You must provide this notice, in writing to the Plan Administrator (or third-party COBRA administrator, if any). In order to protect your rights, you should keep the Plan Administrator (or third-party COBRA administrator, if any) informed of any changes in the address of you, your spouse, and/or your dependents.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under Federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends (or after the employer stops contributing toward the other coverage) because of the qualifying event listed below. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Once the Plan Administrator (or third-party COBRA administrator, if any) receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary has an independent right to elect COBRA. You may elect COBRA on behalf of your spouse who was covered under the group health plan at the time of the qualifying event, and you or your spouse may elect COBRA on behalf of your eligible dependents that were covered under the group health plan at the time of the qualifying event.

The Plan Administrator (or third-party COBRA administrator, if any) will provide qualified beneficiaries with a COBRA election form. Qualified beneficiaries must elect to continue participation within 60 days after your participation ends or you receive this form, whichever is later. The Plan will offer COBRA continuation coverage only after the Plan Administrator (or third-party COBRA administrator, if any) has been notified that a qualifying event has occurred.

When the qualifying event is your death, your entitlement to Medicare benefits, your divorce or legal separation, or a dependent's losing eligibility as dependents, COBRA continuation coverage may last for up to a total of 36 months. When the qualifying event is your termination of employment or reduction of hours of employment and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA for qualified beneficiaries (other than you) may last for up to 36 months after the date of

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Medicare entitlement. In some situations (described below), COBRA may last up to 29 or 36 months. Otherwise, when the qualifying event is your termination of employment or reduction of hours, COBRA generally lasts for up to a total of 18 months. There are two ways in which the 18 month period of COBRA can be extended:

(a) *Disability Extension.* If you or any of your covered dependents is determined by the Social Security Administration ("SSA") to be disabled and you notify the Plan Administrator (or third-party COBRA administrator, if any) in a timely fashion, you and your covered dependents may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA and must last at least until the end of the 18 month period of COBRA. To be eligible for this disability extension, you must notify the Plan Administrator (or third-party COBRA administrator, If any) of the SSA's determination within 60 days of receiving it and prior to the end of the initial 18-month COBRA period. However, if the ruling letter is received before COBRA eligibility begins, the letter must be provided within the first 60 days of electing COBRA. If the SSA determines that the individual is no longer totally disabled, continuation coverage ends. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan Administrator (or third-party COBRA administrator, if any) within 30 days after the SSA's determination.

(b) *Second Qualifying Event Extension.* If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependents can get up to 18 additional months of COBRA coverage, for a total maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator (or third-party COBRA administrator, if any) within 60 days of the occurrence of the second qualifying event. This extension may be available to your spouse and dependents receiving COBRA if you die, become entitled to Medicare benefits, get divorced or legally separated, or if your dependent stops being eligible under the Plan as a dependent, but only if the event would have caused your spouse or dependent to lose coverage under the Plan had the first qualifying event not occurred.

There are a few cases in which a COBRA participant or qualified beneficiary could lose COBRA coverage early. Such person is no longer entitled to COBRA if the participant who becomes covered under another group health plan, fails to make the required contributions on time, becomes entitled to Medicare benefits (under Part A and/or Part B or both, including if someone has also enrolled in Medicare Advantage), or the Employer ceases to provide any health plan benefits.

To continue your group health coverage, you and/or your covered dependents may be charged up to 102% of the full cost of coverage (or 150% in the case of an 11-month extension due to disability). You make this payment monthly during the 18, 29 or 36-month period of continuation coverage. The first premium payment must be received by the COBRA administrator

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within 45 days after the date of the COBRA election and must include your COBRA payment for the entire period from the date coverage ended through the month of the payment. Subsequent premiums must be received by the COBRA administrator within 30 days after the premium due date. Premium payments should be sent to the Plan Administrator's (or third-party COBRA administrator's, if any) address.

If health care FSA coverage is offered under the Plan, COBRA continuation for such coverage ends on the last day of the health care FSA plan year in which the qualifying event occurs, unless your Employer allows the carryover feature, allowing you to carry over up to $500 in unused health care FSA amounts to the next plan year. A COBRA qualifying beneficiary must be provided the health care FSA carryover option if it is provided to active health care FSA participants. The health care FSA carryover cannot last beyond the end of the applicable maximum COBRA coverage period (e.g., 18 months from the date of the COBRA qualifying event). However, COBRA will not be provided under the health care FSA if, as of the date of the qualifying event, you would not receive (during the remainder of the plan year) a benefit under the health care FSA that is more than the amount you would pay for COBRA for the remainder of that plan year. Any carryover permitted by your Employer must be included in determining whether the health care FSA is underspent.

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a 'special enrollment period.' Some of these options may cost less than COBRA continuation coverage.

For more information about your rights under COBRA, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov/.

COBRA rights are generally explained in detail in the Certificate of Coverage issued by an insurance company or in the Group Health Plan. In the event any provision of this document, including the applicable Attachments, fails to comply with the requirements of the applicable law or fails to determine the rights or liability of any party, the provisions of COBRA shall prevail. In no event shall the rights granted by the Plan be greater than those required to be provided by COBRA.

Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act ("GINA") states that health benefit plans may not discriminate on the basis of genetic information relating to eligibility, premiums and contributions. In this regard, GINA generally prohibits private employers with more than 15 employees from the collection or use of genetic information (including family medical history information) by an employer, health plan, or "business associate" of the employer. One exception to this rule is that a minimum amount of genetic testing results may be used if necessary to make a determination regarding a claims payment.

You should be aware that where GINA applies genetic information is treated as protected health information under another Federal law called "HIPAA." The plan must provide that an employer cannot request or require that you reveal whether you have had genetic testing. Neither can

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your Employer require you to undergo a genetic test. An employer cannot use genetic information to set contribution rates or premiums.

There is an exception to GINA's general prohibition against acquiring you or your family's genetic information where your Employer offers voluntary health or genetic services to employees or their family members. Some employers want to offer inducements for employees and their family members to answer questions about their health or to take medical examinations as part of a wellness program; however, your Employer may only offer a limited incentive for your spouse to provide information about his or her current or past health status as part of a voluntary wellness program.

HIPAA Rules

Information you provide for purposes of a health plan sponsored by the Employer may be protected health information under Privacy Standards established under the Health Insurance Portability and Accountability Act ("HIPAA"). Where HIPAA applies, such plan will be operated in accordance with such law and laws that affect this law such as GINA, which makes it clear that genetic information is also protected health information. If you have questions about this law, you should contact the Plan Administrator.

Regarding HIPAA portability, some group health plans are subject to HIPAA portability rules while others are not. Group health plans that are generally not subject to HIPAA portability (and therefore are considered "HIPAA-excepted coverage") include for example certain limited dental and vision plans, as well as long-term care, nursing home care, home health care, or community-based care, specified disease or illness, hospital indemnity or other fixed indemnity, and most FSAs.

In addition, a group health plan that is subject to HIPAA portability must comply with the following:

If a group health plan provides benefits for a type of injury, it may not deny benefits otherwise provided for the treatment of that injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

Note that pre-existing condition exclusions are now prohibited for group health plans.

Mental Health Parity Act

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") generally applies to employers that employ more than 50 employees and its health plan provides for mental health and substance abuse benefits. (Thus, if your Plan does not currently offer any mental health or substance abuse benefits, then MHPAEA does not apply.) These group health plans must cover mental health and substance abuse services in a manner equal to their coverage of predominant medical and surgical services.

Financial and treatment limits for mental health/substance abuse, such as deductibles, co-payments, co-insurance and out-of-pocket expenses, days of coverage, limited networks for services, and other similar limits on dollars, scope, or duration of treatment may not be substantially more limited than for medical/surgical benefits. For example, a plan may not apply separate deductibles for treatment related to mental health or substance use disorders and medical or surgical benefits—they must be calculated as one limit.

To the extent that non-Grandfathered small group plans are required to provide essential health benefits, including mental health and substance abuse disorder benefits, for plan years beginning on or

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after July 1, 2014, such benefits must comply with the final rules issued by the DOL on November 13, 2013.

Michelle's Law

Many health plans extend health coverage to dependents of an employee where they have dependent full-time college students under a certain age. In such a case, a certification of student status may be required by the Plan Administrator for continued coverage under the health plan. Group health plans must provide extended coverage to any of the Participant's dependents who is a full-time student in a postsecondary educational institution that would otherwise lose coverage because of taking medically necessary leave due to a serious illness or injury.

If you have a dependent who is a full-time student with a serious illness or injury, that dependent may be eligible for protection under Michelle's Law. Your Employer may require you to provide written certification of the condition from the child's treating physician in order for your child to be eligible.

If your child is deemed eligible under Michelle's Law, extension of coverage is required for up to 12 months or, if earlier, the date the coverage would otherwise end under the Component Benefit Plan.

While the Affordable Care Act provision that requires extension of coverage for dependents until the end of the month in which a dependent reaches age 26 will often make reliance upon Michelle's Law unnecessary, Michelle's Law still will have relevance in certain circumstances such as its applicability to HIPAA-excepted coverage (to which the ACA does not apply).

Newborns' and Mothers' Health Protection Act

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods. In any case, such plans and insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not in excess of the above periods.

Qualified Medical Child Support Orders

The Employer's group health plans will provide benefits as required by any qualified medical child support order ("QMCSO") in accordance with ERISA. The Employer has established detailed procedures for determining whether an order qualifies as a QMCSO. Participants' spouses and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (the "Affordable Care Act" or "ACA") of 2010 requires the modification of group health plans in a number of ways. Some of these significant changes (which may also be reflected in the applicable Certificates of Coverage) include the following for group health plans *that are neither grandfathered nor HIPAA-excepted coverage*:

(a) If you need to receive emergency services in the emergency department of a hospital, you do not need prior authorization, and your cost-sharing obligations (including co-payments and co-insurance) will be the same whether you are treated at a hospital that is in-network or out-of-network. You are not required to receive prior approval as

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would be applied to care received by preferred providers; however, you may be responsible for the allowed amount under your plan and what is billed by a non-network provider, to the extent permitted by the ACA;

(b) Coverage of minimum preventive care services that have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force must be provided without cost-sharing by the covered person and which also include special provisions for first dollar coverage of certain immunizations, preventive care and screening for infants, children, adolescents, and women;

(c) If your health plan requires you to select a primary care physician ("PCP"), the group health plan or health insurer may designate one for you automatically. In some circumstances, you can designate any participating PCP (who participates in the network and who is accepting new patients) as your PCP; additionally, a participating physician specializing in pediatrics may be selected as the PCP for a covered dependent child; if the group health plan designates a PCP automatically, until you make this designation, the group health plan or health insurer will designate one for you. Where selection of a PCP is required or allowed, contact the Plan Administrator or insurer at the telephone numbers listed as contacts under **Appendix A** for information on the selection process;

(d) A female covered person is permitted to receive services for OB/GYN care without referral by a PCP. That is, prior authorization from a health plan or insurer or from any other person (including a primary care provider) is not necessary in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator or insurer at the telephone numbers listed as contacts under **Appendix A**; and

(e) Internal appeal and external review claim procedures are revised as provided in the "Claims Procedures" section of this SPD.

Significant changes (which may also be reflected in the applicable Certificates of Coverage) include the following for *both grandfathered and non-grandfathered health plans that are not HIPAA-excepted coverage*:

(a) Any lifetime or annual maximum may not be imposed on the following benefits to the extent that they are covered under the Plan: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care (collectively, "Essential Health Benefits"). For purposes of determining whether a benefit or service is an essential health benefit relating to permissible annual or lifetime limits and cost sharing limits

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under the Affordable Care Act, the Plan must choose a benchmark state;

(b) No rescissions in health plan coverage will be allowed except for fraud or an intentional misrepresentation of a material fact and will require 30 calendar days' advance notice to an individual before coverage is rescinded; and

(c) If you have elected coverage for your dependents under your health plan, your child (including step-child, legally adopted child, a child placed for adoption and a child under a QMCSO or National Support Notice) can be covered until the end of the month in which a child turns age 26 regardless of the child's tax dependent status.

The above includes certain minimum provisions of the ACA. In certain cases, a Component Benefit Plan's Certificate of Coverage may be more generous than the ACA requires. Therefore, you should review the Certificate of Coverage for details.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires that health plans offering medical and surgical benefits in connection with a mastectomy also provide coverage in a manner determined in consultation with the attending physician and the patient for (1) all stages of reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to provide symmetrical appearance; (3) prostheses; and (4) treatment of physical complications of the mastectomy, including lymphedema. Where this law applies, these benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the applicable Component Benefit Plan identified in **Appendix A.** Call your Plan Administrator for more information.

Wellness Program

In some circumstances, the Plan may offer wellness programs designed to promote the health and well being of all employees. Some examples of wellness programs include, but are not limited to: providing financial incentives to engage in activities that encourage health lifestyle changes, providing you with information about your current health condition by undergoing health screenings or answering questionnaires, giving you the opportunity to receive health coaching, and participating in disease management programs.

These wellness programs are designed to help mitigate risks and allow you to be more involved in your healthcare, which may lead to a healthier employee population with lower healthcare costs, ultimately saving you and the Employer money.

Information collected as part of any wellness program will be analyzed and considered when developing future wellness programs and making future plan design changes affecting all participants. The terms of any wellness programs will be communicated to you separately as part of open enrollment material or other communications.

Under the Americans with Disabilities Act ("ADA"), any wellness program that includes disability-related inquiries or medical examinations for employees must be voluntary, meaning that it may not (i) require any employee to participate; (ii) deny any employee who does not participate in a wellness program access to health coverage or prohibit any employee from choosing a particular plan; and (iii) take any other adverse action or retaliate against, interfere with, coerce, intimidate,

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or threaten any employee who chooses not to participate in a wellness program or fails to achieve certain health outcomes. Employers must also provide a notice that clearly explains what medical information will be obtained, how it will be used, who will receive it, and the restrictions on disclosure. Finally, an employer must comply with certain incentive limits. Effective January 1, 2019, these incentive limits have been voided.

Under the ADA, any wellness program must also be reasonably designed to promote health or prevent disease, meaning that it cannot (i) require an overly burdensome amount of time for participation; (ii) involve unreasonably intrusive procedures; (iii) be a subterfuge for violating the ADA or other laws prohibiting employment discrimination; or (iv) require employees to incur significant costs for medical examinations.

Any wellness program related to financial incentives offered under the Plan must comply with the requirements and limitations of HIPAA, the ACA, the ADA and related guidance. For example, where a wellness program subject to HIPAA is offered under the Plan, a reward may be offered based on certain standards of achievement. If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call the Plan Administrator, and we will work with you to develop another way to qualify for the reward.

Employer's Rights under the Plan

Employer's Right to Change or End the Plan

Ashford University, LLC reserves the right to terminate, suspend, withdraw, amend or modify the Plan, or any Component Benefit Plan, in whole or in part at any time. Any affiliated employer reserves the right to withdraw from and terminate its participation in the Plan or Component Benefit Plan, thereby terminating, suspending, amending or modifying the Plan as to its Plan participants. Generally, unless specifically provided otherwise in an underlying document relating to the applicable Component Benefit Plan, any amounts remaining in the Plan at termination will be distributed as if they were insurance company refunds/rebates (see heading "Insurance Company Refund").

Employer's Right to Interpret the Plan

Ashford University, LLC has the right to appoint the Plan Administrator of the Plan. The Plan Administrator has discretion to interpret the provisions of the Plan and any Component Benefit Plan, to make factual determinations, and to delegate such authority. The Plan Administrator's and/or delegate's interpretations and decisions are conclusive and binding on all Plan participants.

Employer's Right of Reimbursement

To the extent not inconsistent with the provisions of any underlying documents incorporated by reference in the Plan, the following provisions will control as to any Component Benefit Plan.

The Plan does not provide primary coverage for expenses associated with an injury or illness caused or worsened by the action of any third party which gives rise to a claim against that party, nor does it provide

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primary coverage for such expenses to the extent that there is other applicable coverage from a source other than the Plan (including, but not limited to, medical benefits under an automobile insurance policy). If an employee, spouse, or dependent, or any other person specified as an "Eligible Non-Employee" in **Appendix A** (a "Covered Individual") incurs expenses and receives benefits from the Plan or its carrier(s) as a result of an injury or accident caused by the action of a third party, immediately upon payment of any benefits under the Plan, the Plan will be subrogated (substituted) to all rights of recovery against any person or organization whose conduct or action caused or contributed to the loss for which payment was made by the Plan.

As a condition to participation in or the receipt of benefits under the Plan, a Covered Individual agrees that if such person receives or is entitled to any reimbursement or any other financial recovery from any source, including such Covered Individual's own insurance carrier or another welfare benefit plan (such as a disability plan, if any) sponsored by an employer, whether by judgment, settlement, award, government or worker's compensation benefits, or otherwise, on account of such injury or illness, the Plan has the right to recover the amounts the Plan has paid or will pay as a result of that injury, from any amounts a Covered Individual received from any party, and the Plan has a lien on any such recovery. Similarly, if any person, including any natural person or entity, other than a Covered Individual has possession of funds recovered from a third party as to which any Covered Individuals has or had a claim, then the Plan will be subrogated to that claim and will have a right to recover directly from the person that is holding the funds. By participating in and accepting benefits under the Plan in connection with such an injury or illness, a Covered Individual agrees and is bound to assist the Plan in its attempt to recover from that person, assigns any recovery to the Plan and authorizes such Covered Individual's attorney, personal representative, or insurance company to reimburse the Plan. In the event that a Covered Individual is deceased, the Plan has a right to recover funds from such Covered Individual's estate pursuant to this reimbursement provision. The Plan will not pay attorney fees or costs associated with any Covered Individual's claims without prior express written authorization by the Plan, which the Plan may grant or withhold in its sole discretion. In this regard, the Plan will not be subject to any "make whole" or other subrogation rule that may otherwise apply by law that reduces its right to recover the full amount of its loss unless the Plan has expressly agreed to do so in writing. Rather, the Plan is entitled to full reimbursement:

(a) before the Covered Individual is entitled to retain any part of such financial recovery, regardless of the stated reason for the financial recovery or whether the Covered Individual has other costs or suffered other injuries not paid for or compensated by the Plan (notwithstanding any "Make Whole Doctrine");

(b) without regard to any claim of fault on the part of the Covered Individual, whether under comparative negligence or otherwise;

(c) without reduction for attorneys' fees and other costs incurred by the Covered Individual in making a recovery without the prior express written consent of the Plan (notwithstanding any "Fund Doctrine," "Common Fund Doctrine," or "Attorneys' Fund Doctrine"); and

(d) notwithstanding that the recovery to which the Plan is subrogated is paid to a decedent, a minor, a decedent's

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estate, or an incompetent or disabled person.

A Covered Individual, and individuals acting on a Covered Individual's behalf, including attorneys, will do nothing to prejudice the Plan's subrogation and reimbursement rights and will, when requested, provide the Plan with information and cooperate with the Plan in the enforcement of its subrogation and reimbursement rights. It is your duty, and the duty of individuals acting on your behalf, to notify the Plan Administrator within 45 days of the date of the injury or the date when you give notice to any other party, including an attorney, of your intention to pursue or investigate a claim to recover damages on behalf of a Covered Individual. The payment of benefits under the Plan on account of an injury or illness as a result of an action of a third party is contingent on the Covered Individual:

(a) informing the Plan Administrator of the action to be taken by the Covered Individual;

(b) agreeing (in such form and to such documents as the Plan may require) to the Plan being reimbursed from any recovery from a third party and subrogated to any right of recovery the Covered Individual has against a third party;

(c) refraining from action which would prejudice the Plan's subrogation rights (including, but not limited to, making a settlement which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan); and

(d) cooperating in doing what is reasonably necessary to assist the Plan in any recovery.

If the Covered Individual should fail or refuse to comply with these subrogation and right of reimbursement provisions, the Covered Individual is not entitled to benefits under the Plan and must reimburse the Plan for any and all costs and expenses, including attorneys' fees, incurred by the Plan in enforcing its rights hereunder. The Plan may determine not to exercise all of the reimbursement and/or subrogation rights described here in certain types of cases, with respect to certain covered groups, or with respect to certain geographic areas, without waiving its right to enforce its rights in the future as to other groups or in other geographic areas.

For purposes of this section, "reimbursement" includes all direct and indirect payments to a Covered Individual for injury or illness from any source, by way of settlement, judgment, or any other means, including but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, no-fault automobile insurance coverage, and homeowner's insurance.

Other Continuation / Conversion Privileges

You may be eligible for continuation of coverage under a COBRA-type continuation of coverage arrangement mandated in the State to which your coverage applies (for example, California, New York, or Georgia) for certain insured benefits. The availability of this continuation coverage and the rules concerning eligibility should be set forth in the policy of the insurance company allowing the continuation of coverage. Since the time period for exercising your right to elect continuation of coverage may be limited, you must inquire with your

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applicable insurance company as soon as possible once you are no longer eligible for a component benefit under the Plan.

Also, when you are no longer eligible under the Plan (either as an active participant or as a qualified beneficiary receiving continuation coverage), you may be eligible to obtain an individual conversion policy for one or more of your insured benefits. The availability of this conversion coverage and the rules concerning your eligibility should be set forth in the policy of the insurance company allowing the conversion privilege. Since the time period for exercising your conversion privileges may be limited, you should inquire with your applicable insurance company as soon as possible once you are no longer eligible for a component benefit under the Plan.

ERISA Rights

You are entitled to certain rights and protections under ERISA. ERISA provides that Plan participants are entitled to:

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

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

- Receive a summary of the Plan's annual financial report (Form 5500), if any is required by ERISA to be prepared. Where the annual financial report must be prepared, the Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

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

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your Employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining your benefits under the Plan or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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- Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any is required to be prepared, from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

- If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (discussed under the heading Claims Procedure), you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your benefits or the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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Appendix A: Component Benefit Plans

The information below is effective July 1, 2019, unless otherwise indicated below.

Component Benefit Plans Offered Under the Plan

Below is a list of each Component Benefit Plan and the eligibility and participation requirements of those plans. Also listed is the name (and in the case of group health plan claims, the address and telephone number) of the individual insurance company that provides benefits (if any) and reviews claims relating to its insurance policy. Also below may be a list of the name and address of the TPA (if any) that reviews claims made under a Component Benefit Plan as well as the telephone number to call for questions regarding claims procedures and forms.

Generally, unless otherwise indicated below or as provided in **Appendix B**, an eligible employee under the Plan is any regular common-law employee of Ashford University, LLC who is not a leased employee, contract worker or independent contractor, seasonal employee, variable hour employee, or former employee, and such regular common-law employee is eligible to participate in and receive benefits under one or more of the Component Benefit Plans. Non-resident aliens are also not eligible unless specifically included under "Eligible Employees" below. To determine whether you are eligible to participate in a Component Benefit Plan, please read the eligibility information below for the applicable Component Benefit Plan.

Medical Benefits (1500 Choice Fund with HRA)	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is "Date of Hire"
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Registered Domestic Partners
Contribution Source(s)	Employer and Employee
Contributions Pre-Taxed?	Yes, subject to Employer's Section 125 Cafeteria/POP Plan Document. A domestic partner who is not a dependent is post-tax for Federal tax purposes.
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna; P.O. Box 182223; Chattanooga, TN 37422; 800-244-6224
Grandfathered Health Plan	No
Look-Back Provisions	No
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

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Medical Benefits (2000 Choice Fund with HSA)	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is "Date of Hire"
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Registered Domestic Partners
Contribution Source(s)	Employer and Employee
Contributions Pre-Taxed?	Yes, subject to Employer's Section 125 Cafeteria/POP Plan Document. A domestic partner who is not a dependent is post-tax for Federal tax purposes.
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna; P.O. Box 182223; Chattanooga, TN 37422; 800-244-6224
Grandfathered Health Plan	No
Look-Back Provisions	No
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Medical Benefits (2500 Choice Fund with HRA)	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is "Date of Hire"
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Registered Domestic Partners
Contribution Source(s)	Employer and Employee
Contributions Pre-Taxed?	Yes, subject to Employer's Section 125 Cafeteria/POP Plan Document. A domestic partner who is not a dependent is post-tax for Federal tax purposes.
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna; P.O. Box 182223; Chattanooga, TN 37422; 800-244-6224
Grandfathered Health Plan	No
Look-Back Provisions	No
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

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Medical Benefits (CA Select HMO)	
Eligible Employees *	Southern CA Employees Only - working at least 30 hours per week
Participation Begins *	On 1st of Month Coinciding with or Following Satisfaction of Day Waiting Period
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	Employees residing outside of the Southern CA area
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Registered Domestic Partners
Contribution Source(s)	Employer and Employee
Contributions Pre-Taxed?	Yes, subject to Employer's Section 125 Cafeteria/POP Plan Document. A domestic partner who is not a dependent is post-tax for Federal tax purposes.
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna; P.O. Box 182223; Chattanooga, TN 37422; 800-244-6224
Grandfathered Health Plan	No
Look-Back Provisions	No
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Dental Benefits (PPO)	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is "Date of Hire"
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Registered Domestic Partners
Contribution Source(s)	Employer and Employee
Contributions Pre-Taxed?	Yes, subject to Employer's Section 125 Cafeteria/POP Plan Document. A domestic partner who is not a dependent is post-tax for Federal tax purposes.
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna; P.O. Box 188037; Chattanooga, TN 37422; 800-244-6224
Grandfathered Health Plan	No
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

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Vision Benefits	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is "Date of Hire"
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Registered Domestic Partners
Contribution Source(s)	Employer and Employee
Contributions Pre-Taxed?	Yes, subject to Employer's Section 125 Cafeteria/POP Plan Document. A domestic partner who is not a dependent is post-tax for Federal tax purposes.
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna; P.O. Box 385018; Birmingham, AL 35238; 877-478-7557
Grandfathered Health Plan	No
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Basic Life & AD&D Benefits	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is "Date of Hire"
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	None
Contribution Source(s)	Employer Only
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna; 1601 Chestnut Street; Philadelphia, PA 19192; 800-732-1603
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Voluntary Optional Term Life Benefits	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is "Date of Hire"
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Registered Domestic Partners
Contribution Source(s)	Employee Only
Contributions Pre-Taxed?	No
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

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STD Benefits	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is "Date of Hire"
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	None
Contribution Source(s)	Employer Only
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna; 1601 Chestnut Street; Philadelphia, PA 19192; 800-732-1603
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

LTD Benefits	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is "Date of Hire"
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	None
Contribution Source(s)	Employer Only
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna; 1601 Chestnut Street; Philadelphia, PA 19192; 800-732-1603
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Employee Assistance Plan Benefits (EAP)	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is "Date of Hire"
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Domestic Partners, Registered Domestic Partners
Contribution Source(s)	Employer Only
Funding Arrangements	Self-funded
Plan Administered By	Cigna; P.O. Box 182223; Chattanooga, TN 37422; 800-244-6224
Claim Fiduciary	Plan Administrator/Employer
Trustee	None
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

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Flexible Spending Account (FSA) Benefits	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is "Date of Hire"
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	None
Contribution Source(s)	Employee Only
Contributions Pre-Taxed?	Yes, Subject to Employer's Section 125 Cafeteria/POP Plan Document
Funding Arrangements	Self-funded
Plan Administered By	Discovery Benefits; 4321 20th Ave S; Fargo, ND 58103; 866-451-3399
Claim Fiduciary	Discovery Benefits; 4321 20th Ave S; Fargo, ND 58103
Trustee	None
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Hospital Indemnity Benefits	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is "Date of Hire"
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Registered Domestic Partners
Contribution Source(s)	Employee Only
Contributions Pre-Taxed?	No
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna; P.O. Box 55290; Phoenix, AZ 85078; 860-730-6460
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Accident Benefits	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is "Date of Hire"
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Registered Domestic Partners
Contribution Source(s)	Employee Only
Contributions Pre-Taxed?	No
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna; P.O. Box 55290; Phoenix, AZ 85078; 860-730-6460
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

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Critical Illness Benefits	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is "Date of Hire"
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Registered Domestic Partners
Contribution Source(s)	Employee Only
Contributions Pre-Taxed?	No
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna; P.O. Box 55290; Phoenix, AZ 85078; 1-860-730-6460
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Prepaid Legal Benefits	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is "Date of Hire"
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Registered Domestic Partners
Contribution Source(s)	Employee Only
Contributions Pre-Taxed?	No
Funding Arrangements	Insured Benefit Program
Insurance Carrier	MetLaw; 800-821-6400
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

New York State DBL/PFL Benefits	
Eligible Employees *	New York Employees Only
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is "Date of Hire"
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	None
Contribution Source(s)	Employer Only
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna; 1601 Chestnut Street; Philadelphia, PA 19192; 800-732-1603
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

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New Jersey State DBL/PFL Benefits	
Eligible Employees *	New Jersey Employees Only
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is "Date of Hire"
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	None
Contribution Source(s)	Employer Only
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna; 1601 Chestnut Street; Philadelphia, PA 19192; 800-732-1603
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Hawaii State DBL/PFL Benefits	
Eligible Employees *	Hawaii Employees Only
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is "Date of Hire"
Participation Ends *	Date Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	None
Contribution Source(s)	Employer Only
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Cigna; 1601 Chestnut Street; Philadelphia, PA 19192; 800-732-1603
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Wellness Program	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of Waiting Period. Waiting Period is "Date of Hire"
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Registered Domestic Partners
Contribution Source(s)	Employer Only
Funding Arrangements	Self-funded
Plan Administered By	Employer / Plan Sponsor
Claim Fiduciary	Plan Administrator/Employer
Trustee	None
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

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Appendix B: Look-Back Provisions

Please see your Plan Administrator for additional information on whether your Employer has adopted the optional look-back language.

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