University of San Francisco
Welfare Benefit Plan

Master Plan Document / Master Summary Plan Description
Amended Effective January 1, 2015

This document, together with the additional documents provided along with it, constitute the written plan document required by ERISA § 402 and the Summary Plan Description required by ERISA § 102.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the notice reproduced in Appendix B for more details.
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1. Definitions

Capitalized terms used in this document have the following meanings:

**AD&D**  "AD&D" means accidental death and dismemberment insurance.

**Affordable Care Act**  “Affordable Care Act” means the Patient Protection and Affordable Care Act, as amended.

**COBRA**  "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**Code**  "Code" means the Internal Revenue Code of 1986, as amended.

**Company**  "Company" means University of San Francisco or any successor thereto.

**DCAP**  "DCAP" means a dependent care assistance program that may be established by the Company under a separate document. The DCAP is a benefit program under the Plan. It may allow you to use pre-tax dollars to pay for the care of your eligible dependents while you are at work.

**Employee**  "Employee" means any common-law employee of the Company who satisfies the eligibility provisions in this document and is not excluded from participation by the terms of an applicable benefit program, except employees classified or treated by the Company as independent contractors, or as an employee of an employment agency.

**ERISA**  "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

**Health FSA**  "Health FSA" means a health flexible spending account plan that may be established by the Company under a separate document. The health FSA is a benefit program under the Plan. It allows you to use before-tax dollars to pay for most medical and dental expenses not reimbursed under other programs.

**HIPAA**  "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

**NMHPA**  "NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

**Plan**  "Plan" means the Company Welfare Benefits Plan and includes this document, written amendments and updates to this document, and the terms of all policies and component benefit programs listed in Section 14.

**Plan Administrator**  "Plan Administrator" means the Company.
2. Introduction

The Company maintains the Plan for the exclusive benefit of eligible Employees and eligible family members or “dependents.” It is important that you share this document and the materials referenced here in with your covered dependents. The Plan provides health and welfare benefits through the benefit programs listed in Section 14. See Section 14 for a listing of benefit programs and the entities that help administer the programs.

Each of these benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another document (a "Benefit Description"). A Benefit Description will be available from the insurer (if the benefit is fully-insured) or Plan Administrator (if the benefit is self-funded). Whether a benefit program is fully-insured or self-funded is noted in Section 14.

This document and its attachments constitute the plan document required by ERISA § 402. This document and its attachments, coupled with the information booklets and other descriptive materials provided for benefits as described in Section 14 constitutes the wrap Summary Plan Description as required by ERISA § 102.

3. General Information About the Plan

<table>
<thead>
<tr>
<th>Plan Name:</th>
<th>University of San Francisco Welfare Benefit Plan</th>
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<tbody>
<tr>
<td>Type of Plan:</td>
<td>Welfare plan providing coverages listed in Section 14. The Plan also includes a cafeteria plan under Code § 125.</td>
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<tr>
<td>Plan Year:</td>
<td>January 1 to December 31.</td>
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<td>Plan Number:</td>
<td>501</td>
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<tr>
<td>Effective Date:</td>
<td>January 1, 1998. The Plan has been amended several times since its original effective date, most recently as of January 1, 2015.</td>
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<td>Funding Medium and Type of Plan Administration:</td>
<td>Some benefits under the Plan are self-funded, and some are fully-insured. See Section 14 for a description of the benefit programs and whether they are self-funded or fully-insured. For benefit programs which are fully-insured, benefits are insured under a group contract entered into between the Company and insurance companies or HMO. The insurance companies and/or HMO, not the Company, are responsible for paying claims with respect to these programs. The Company shares</td>
</tr>
</tbody>
</table>
responsibility with the insurance companies and/or HMO for administering these program benefits, as described below.

For benefit programs which are self-funded, the Company is responsible for processing and paying appropriate claims. The Company may hire a third party administrator (a "TPA") to process claims.

Premiums for Employees and their eligible family members may be paid in part by the Company out of its general assets and in part by Employees' pre-tax and/or post-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and on request for each of the benefit programs, as applicable.

The Company provides Employees the opportunity to pay for benefits on a pre-tax basis through a cafeteria plan. Appendix C provides information with regard to such a plan.

Plan Sponsor: The employer is the Plan Sponsor.

University of San Francisco
2130 Fulton St.
San Francisco, CA 94117
1-415-422-2442

Plan Sponsor's Employer Identification Number: 94-1156628

Insurance Companies/HMO: See a complete list under the heading Plan Provider Information later in this document.

Plan Administrator: Attention: Director of Employee Benefits
University of San Francisco
2130 Fulton St.
San Francisco, CA 94117
1-415-422-2442

Named Fiduciary: University of San Francisco
2130 Fulton St.
San Francisco, CA 94117
1-415-422-2442

Agent for Service of Legal Process: President
University of San Francisco
2130 Fulton St.
San Francisco, CA 94117
1-415-422-2442

Service for legal process may also be made on the Plan Administrator.

Benefits hereunder may be provided pursuant to an insurance contract or pursuant to a governing document adopted by the Company. If so, these contracts are made a part of this Plan document, and the contracts and Plan document should be construed as consistent, if possible. If the terms of this Plan document conflict with the terms of such insurance contract or other governing document, then the terms of the insurance contract or
governing document will control, with the exception of defining eligible employees and dependents, which is determined by the Company, unless otherwise required by law.

4. Eligibility and Participation Requirements

Eligibility and Participation
An eligible Employee with respect to the Plan will be an Employee who is eligible to participate in and receive benefits under one or more of the benefit programs. To determine whether you or your family members are eligible to participate in a benefit program, please see Section 14.

Certain benefit programs require that you make an annual election to enroll for coverage. Generally, you cannot enroll, drop coverage, or change your or your dependents’ coverage under the plan except during annual Open Enrollment. However you may be able to add or drop coverage for yourself or a dependent during the plan year if you experience an event that triggers a HIPAA Special Enrollment Right (see discussion below) or if you have a Status Change Event (see Appendix C for an explanation of Status Change Events). Please review the rules for changing your benefits elections described in Appendix C very carefully as the rules regarding making benefits changes mid-year must be strictly enforced.

Information about enrollment procedures is provided by the Company. Information about when your participation begins in various benefit programs is found under Section 14. You must follow any required enrollment procedures. Also, always make sure that the Company has your current home address and other contact information for you and your covered dependent to correctly administer your benefits and to send you important benefits information.

Eligible Dependent Status
Consult your plan’s carrier documentation for details as to whether your child can participate in a particular benefit program and any limits on such participation. For example, children covered under the Medical benefit program generally can be covered until the end of the month during which they reach age 26. However, coverage may end earlier for other benefits (or may not be available at all).

You cannot be covered both as an employee and as a dependent under the plan.

Full Time Status and the ACA
Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee who works on average 130 hours per month. Employers may also face penalties if they do not offer major medical coverage to substantially all full-time employees or if they coverage they offer is unaffordable or does not meet a minimum value standard. The Company determines full-time status using the “Look-back” method. ACA full-time status is not a guarantee of major medical benefits eligibility. Benefits eligibility is described in Section 14.

Special Enrollment Provisions under HIPAA
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a special enrollment period for the Medical benefit program (or similar benefit programs providing medical benefits) may be available, usually if you lose medical coverage under certain conditions or when you acquire a new dependent by marriage, birth, or adoption.

If you are declining enrollment for yourself or your dependents (including your spouse/registered domestic partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your
dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

In addition, if you declined enrollment in the Plan for yourself or your dependents (including a spouse/registered domestic partner) because of coverage under Medicaid or a State Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

Finally, if you declined enrollment in the Plan for yourself or your dependents (including a spouse/registered domestic partner), and you or a dependent later becomes eligible for state assistance through Medicaid or a State Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance.

*Medicaid and State Children's Health Insurance Program premium assistance are not available with respect to coverage under a health FSA or a high-deductible health plan. Thus, this special enrollment event will not apply to such plans.*

**Coverage During Certain Leaves of Absence**

Certain Federal (and State) statutes like the Family and Medical Leave Act (FMLA) require that eligibility for medical benefits continue for employees on those protected leaves on the same terms as for active employees. When wages continue during such a leave, your contributions will continue to be deducted from those wages on a pre-tax basis. When such a leave is unpaid, you are still required to pay your portion of the premium. Your portion of the premium may be paid as regular monthly intervals during the leave on a post-tax basis.

You may also generally discontinue coverage at the beginning of such an unpaid leave and when you return your benefits will either be reinstated or you may re-enroll for the remainder of the coverage period or plan year.

Human Resources must determine whether or not you are eligible for a statutory or other leave of absence.

**Termination of Participation**

Your participation and the participation of your spouse/registered domestic partner and dependents in a benefit program will terminate according to the terms of the specific benefit program. Generally, coverage for most benefit programs terminates on the last day of the month in which you terminate employment, but certain benefit programs may provide coverage only through the date your employment terminates. Please see Section 14 for further information on the date participation in a specific benefit program will terminate.

Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below the required hourly threshold for the particular benefit, if you engage in fraud or make an intentional misrepresentation of a material fact, or for any other reason as set forth in the attached documents. You should consult Section 14 for a general summary and the attached documents for specific termination events and information.

Coverage may be terminated retroactively in the normal course of business due to a participant’s termination of employment, nonpayment of premiums, loss of dependent eligibility or other, similar factors. When you or a
dependent lose eligibility for benefits, regardless of whether or not you timely report that loss of eligibility, a change to any existing salary reduction election will be made automatically. To the extent that the coverage at issue does not allow for retroactive termination of that coverage and election to the date of the loss of eligibility, such changes will be prospective. If coverage can be terminated retroactively to the date of the loss of eligibility, or sometime thereafter, excess salary reduction contributions will be refunded on a post-tax basis to the date the termination of coverage can be made effective.

Any person claiming benefits under the Plan shall furnish the Company, any insurance company or other entity working on behalf of the Plan or a benefit program with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under the Plan or a benefit program. This may include but is not limited providing social security numbers, birth certificates, marriage certificates, or proof of dependent eligibility. Failure to cooperate and provide such information will lead to a loss of eligibility for benefits.

Knowingly enrolling an ineligible dependent in plan benefits constitutes fraud and is considered a material misrepresentation that will result in termination of coverage as well as other disciplinary action up to and including termination of employment. Eligibility for benefits is described in Section 14. If you have questions about whether a dependent is eligible you must contact Human Resources before enrolling that dependent.

**COBRA Rights**

You may be eligible for COBRA or conversion policies when your coverage for a medical benefit program under this Plan terminates. Information about continuation coverage or conversion is contained in Appendix A. If you have questions about this law or these rights, please contact the Plan Administrator (for benefit programs that are self-funded) or the insurance carrier (if the benefit is fully-insured). You can determine whether a benefit program is self-funded or fully-insured by consulting Section 14.

For the Health FSA benefit program, COBRA continuation coverage cannot extend beyond the end of the Plan Year (including any 2½ month grace period). COBRA continuation coverage will not be offered with respect to the Health FSA benefit program if your Health FSA is overspent, unless otherwise required by applicable law.

**5. Summary of Plan Benefits**

**Benefits and Contributions**

The Plan provides you and your eligible spouse/registered domestic partner and dependents with the benefit programs listed in Section 14. A summary of each benefit program provided under the Plan may be provided in the attached documents (such as a certificate of insurance booklet, summary plan description for a specific benefit program or other governing document). **Note that some of the attached documents may be labeled as a "summary plan description." If so, that document will only be a summary of the specific benefit program to which it relates. Notwithstanding any of the terms of such a document, that document is not the formal, single "Summary Plan Description" for this Plan. Rather, this document constitutes the formal, single "Summary Plan Description."**

The cost of the benefits provided through the benefit programs may be funded in part by Company contributions and in part by pre-tax and/or post-tax employee contributions. The Company will determine and periodically communicate your share of the cost, if any, of the benefit programs. The Company reserves the right to change that determination.
The Company will make its contributions, if any, in an amount that (in the Company’s sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Company will pay its contribution and your contributions to any insurance carrier or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to, or on behalf of, you or your eligible family members from the Company’s general assets. Your contributions toward the cost of a particular benefit program will be used in their entirety prior to using Company contributions to pay for the cost of such benefit program.

Medical benefits under this Plan may be subject to cost-sharing provisions, premiums, deductibles, co-insurance, copayment amounts, annual or lifetime limits, pre-authorization requirements or utilization review. There may also be limitations on the selection of primary care or network providers, limits on emergency medical care, or limited coverage for preventive services, drugs, medical tests, medical devices or medical procedures. These limitations are set forth in the attached documents.

Certain prescription drug benefits are considered “Creditable Coverage” under Medicare Part D. The attached documents provide details regarding this coverage and an annual notice (attached and incorporated by reference in Appendix B) explains how this creditable coverage works for these prescription drug benefit programs.

The Plan will provide benefits in accordance with the requirements of all applicable Federal laws regulating group health plans, such as COBRA, HIPAA, NMHPA, WHCRA and the Affordable Care Act. A brief summary of some of these laws is below.

**Newborns’ and Mothers’ Health Protection Act (NMHPA) of 1996**
Group health plans and health insurance issuers 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 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 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Women’s Health and Cancer Rights Act (WHCRA) of 1998**
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.
**Qualified Medical Child Support Orders**
Group health plans and health insurance issuers generally must provide benefits as required by any qualified medical child support order, or "QMCSO". The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

**Lifetime and Annual Limits**
Any lifetime or annual limit on the dollar value of “essential health benefits” under major medical plans offered by the Plan no longer applies.

For more information on “essential health benefits” refer to the terms of policies and benefit program materials listed in Section 14. These documents are provided to you during enrollment and are available from Human Resources, the insurer (if the benefit is fully-insured), or Plan Administrator (if the benefit is self-funded).

6. **Grandfather Status under the Affordable Care Act**

**Non-Grandfathered Benefit Programs Under the Affordable Care Act**

The following benefit programs that provide health benefits are not “grandfathered health plans” under the Affordable Care Act:

- Anthem Blue Cross PPO
- Kaiser Northern California HMO
- Kaiser Southern California HMO
- Kaiser Colorado HMO
- Kaiser Mid-Atlantic HMO

These benefit programs must, under the Affordable Care Act, provide additional protections. The protections provided by the Affordable Care Act include the following:

**Preventive Services covered at 100%**: In-network preventive care services will be covered at 100% with no cost sharing (e.g., copayment, coinsurance percentage, deductible, etc.). Preventive services include those services outlined in the [US Preventive Services Taskforce recommendations](https://www.uspreventiveservicestaskforce.org/) (services rated “A” or “B”). Please see the attached documents for the preventive services included at no cost share.

**Non-Network Emergency Services covered as In-Network**: Emergency services must be covered without the need for prior authorization, regardless of the participating status of the provider or facility, and at the in-network cost sharing level.

7. **How the Plan Is Administered**

**Plan Administration**
The administration of the Plan is under the supervision of the Plan Administrator. The Plan Administrator is a named fiduciary within the meaning of ERISA § 402 and has full discretionary authority to administer the Plan, to
interpret the Plan, and to determine eligibility for participation and for benefits under the terms of the Plan. However, insurers and parties that have entered into administrative service agreements (Third Party Service Providers or TPAs) assume sole responsibility for their performance under applicable policies or administrative services agreements and, under ERISA, may be fiduciaries with respect to their performance.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. (However, as noted below, one or more insurance companies may have these responsibilities with respect to fully-insured benefits.)

The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility. The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

**Power and Authority of Insurance Company**
As detailed in Section 14, certain benefits under the Plan may be fully insured. The insurance companies are responsible for (1) determining eligibility for and the amount of any benefits payable under their respective benefit programs and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective benefit programs.

**Questions**
If you have any general questions regarding the Plan, or your eligibility for or the amount of any benefit payable under any benefit program, please contact the Plan Administrator or the appropriate insurance company as applicable.

8. **Circumstances Which May Affect Benefits**

**Denial or Loss of Benefits**
Your benefits (and the benefits of your eligible spouse/registered domestic partner and dependents) will cease when your participation in the Plan terminates. See Section 14. Your benefits will also cease on termination of the Plan.

**Right to Recover Benefit Overpayments and Other Erroneous Payments**
The Plan and its benefit programs (including any insurance company on behalf of a benefit program) have all necessary or helpful rights to subrogation or reimbursement of benefits. If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan, the recipient of such benefit (the "Recipient") shall be responsible for refunding the overpayment to the Plan or insurance company to the fullest extent permitted by law. In addition, if the Plan or insurance company makes any payment that, according to the terms of the Plan, policy or contract should not have been made, the insurance company, the Plan Administrator, or the Plan Sponsor (or designee) may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made due to the insurance company's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party.
As may be permitted in the sole discretion of the Plan Administrator or insurance company, the refund or repayment may be made in one or a combination of the following methods: (a) as a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

Any benefit payments or reimbursements made by check must be cashed or deposited within one year after the check is issued. If any check or other payment for a benefit is not cashed or deposited within one year of the date of issue, the Plan will have no liability for the benefit payment and the amount of the check will be deemed a forfeiture. No funds will escheat to any state.

9. Amendment or Termination of the Plan

Amendment or Termination
The Plan and any benefit program under the Plan may be amended or terminated at any time, in the sole discretion of the Company as Plan sponsor, by a written instrument signed by an authorized individual. Some benefit programs may also be amended or terminated by an insurance carrier, as more fully described in any attached documents from an insurance carrier. The policies and agreements may also be amended or terminated at any time in accordance with their terms. No individual (including a retired employee) shall have a right to continuing benefits except to the extent required by law.

10. No Contract of Employment/No Assignment

The Plan is not intended to be, and may not be construed as, constituting a contract or other arrangement between you and the Company to the effect that you will be employed for any specific period of time.

Except as may otherwise be specifically provided in this Plan, the benefit programs, or applicable law, an individual’s rights, interests or benefits under this Plan or the benefit programs shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the benefit programs, and any such attempt shall be void.

11. Claims Procedures

Claims for Fully-Insured Benefits
For purposes of determining of the amount of, and entitlement to, benefits of the benefit programs provided under insurance contracts or policies, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to benefits.

To obtain benefits from the insurer of a benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer’s form.

The insurance company will decide your claim in accordance with its reasonable claims procedures as required by ERISA.
See the appropriate certificate of insurance booklet for details regarding the insurance company's claims procedures. You must fully follow and exhaust these claims procedures before you can file a lawsuit in state or federal court. You may have a right to seek external review of your claims, if so noted in the applicable insurance contract or policy.

Claims for Self-Funded Benefits
For purposes of determining the amount of, and entitlement to, benefits under the benefit programs which are self-funded, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan.

To obtain benefits from a benefit program which is self-funded you must complete, execute and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence, as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. You may have a right to seek external review of your claims, if so noted in the applicable attached document for the self-funded benefit program.

See the appropriate benefits description for information about how to file a claim and for details regarding the claims procedures applicable to your claim. You must fully follow and exhaust these claims procedures before you can file a lawsuit in court.

12. Statement of ERISA Rights

This Statement of ERISA Rights applies to those benefit programs which are subject to ERISA. Not all benefit programs which are part of this Plan will be subject to ERISA. The following benefit programs are not subject to ERISA: Cafeteria plan and DCAP.

Your Rights
As a participant in an ERISA plan you are entitled to certain rights and protections under ERISA. ERISA provides that, as a participant, you are entitled to:

- examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor (if any) such as annual reports and Plan descriptions;
- obtain copies of the benefit program documents and other program information on written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies);
- receive a summary of the Plan's annual financial report, if any (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, spouse/registered domestic partner, or 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 this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights; and
Fiduciary Obligations
In addition to creating rights for participants, ERISA imposes duties on the people who are responsible for the operation of the benefit program. These people, called "fiduciaries" of the program, have a duty to operate the program prudently and in the interest of you and other program participants. Fiduciaries who violate ERISA may be removed and may be required to reimburse the Plan for any losses they have caused the program.

No Discrimination
No one, including the Company or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining welfare benefits or exercising your rights under ERISA.

Right to Review
If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan Administrator review and reconsider your claim.

Filing Suit
Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator 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 that is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a court.

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of the internal claims and appeals procedure is required prior to filing suit.

If it should happen that benefit program fiduciaries misuse the Program'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 (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Questions
If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 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.

13. General Information

COBRA
Benefit programs which provide health benefits generally are subject to the federal law known as COBRA. COBRA generally allows covered participants and beneficiaries to continue in the benefit program, even after a "qualifying event" occurs. For more information about COBRA please see Appendix A. You may also have state law continuation or conversion rights.
**Subrogation and Reimbursement.** If an individual has a claim for benefits under this Plan or any benefit program, and that individual acquires any right or action against a third party for the person's injury, sickness or other illness which is so covered, then: (a) the Plan shall be entitled to reimbursement for such benefits from such third party up to 100% of the benefits paid by the Plan; and (b) the Plan is automatically subrogated to all such rights or claims of the covered person. The covered person shall cooperate fully with the Plan in the enforcement of the Plan’s subrogation and reimbursement rights. In addition, the person shall permit suit to be brought in the person’s name under the direction of and at the expense of the Company if the Company so chooses. The Plan shall not be liable for such a person’s attorney’s fees absent prior written approval from the Plan. The Plan Administrator may require the receipt of a signed and dated subrogation and reimbursement agreement from the person before advancing any monies.

The failure or refusal of a covered person to fully cooperate with the Plan in the enforcement of the Plan’s subrogation and reimbursement rights shall result in a forfeiture of all benefits payable to that person, even if such benefits have already been paid, in which event the Company shall retain a right to recover paid benefits which are forfeited in such a manner.

The Company, on behalf of this Plan, shall have a first priority right to recover from and a lien against any payment, whether designated as a payment for medical benefits or any other type of damages, from the proceeds of any recovery, including but not limited to any settlement, award or judgment which results from a claim or lawsuit by or on behalf of a covered person who received benefits under this Plan (even if such covered person is not made whole). The plan is not required to contribute to any expenses or fees (including attorney’s fees or costs) incurred in obtaining the funds. The plan’s recovery will not be limited or reduced by doctrines (equitable or other) including but not limited to, the make-whole doctrine, contributory or comparative negligence, the common fund doctrine. Notice of the Plan’s claim shall be sufficient to establish this Plan’s lien against the third party or insurance carrier. The Company shall be entitled to deduct the amount of the lien from any future claims payable to or on behalf of the covered person or payee if the covered person or payee fails to promptly notify the Plan Administrator of a payment received from a third party or insurance carrier that is subject to this Plan’s subrogation and reimbursement rights.

In the event that the Plan obtains a recovery against a third party in excess of payments made to or on behalf of the covered person and reasonable out of pocket expenses of the recovery, then the Plan shall pay to the covered person that excess amount recovered by the Plan.

In the event of any direct conflict between this Section 13 and the subrogation and reimbursement provisions in any benefit program, the subrogation and reimbursement provisions in the benefit program shall control. Otherwise, the provisions of this Section 13 shall apply and may supplement those contained in any benefit program.

The above provisions of this "Subrogation and Reimbursement" section apply with respect to a benefit program that is self-funded and does not, in its governing documents (but excluding this Plan document) have a subrogation and reimbursement section. If the benefit program does have such a section that section shall control. With respect to a fully-insured benefit program, the contract or policy from the insurer shall control with respect to subrogation and reimbursement matters.

**No Vesting of Benefits.** Nothing in the Plan, nor anything in any benefit program, shall be construed as creating any vested rights to benefits in favor of any employee, former employee or covered person.

**Waiver and Estoppel.** No term, condition, or provision of this Plan or any benefit program shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan or benefit program, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a
continuing waiver unless explicitly made so, and shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No covered person other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purposes.

Effect on Other Benefit Plans. Amounts credited or paid under this Plan or any benefit program shall not be considered to be compensation for purposes of any benefit program hereunder or any qualified or nonqualified pension plan maintained by the Company unless expressly provided in such benefit program or qualified or nonqualified pension plan, as applicable, or if required by applicable law. The treatment of amounts paid under this Plan or any benefit program for purposes of any other employee benefit plan maintained by the Company shall be determined under the provisions of the applicable employee benefit plan.

Severability. If any provision of this Plan or any benefit program is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

Rebates. In some situations, a rebate may be paid by an insurance company which provides coverage under the Plan. For example, a rebate may be provided under the Medical Loss Ratio ("MLR") rules, which are part of the Affordable Care Act. Except as specifically and unambiguously provided in a Benefit Description, or as otherwise required by applicable law, any rebate from any source will be:

☒ An asset of the Plan in proportion to how much of the rebate relates to Employee, participant or beneficiary contributions. The portion relating to Company contributions shall not be considered a Plan asset. The Company will have the ability to make certain assumptions or minor changes (such as rounding to the nearest $1 or $10) when determining the amount which is considered a plan asset. The Company shall have discretion to determine how to use all amounts. Amounts which are plan assets will be used to benefit individuals selected by the Company. This group of individuals may not be identical to the group which relates to the rebate. In addition, certain individuals can receive the rebate (or the benefit of the rebate) even if the rebate related to a different benefit, to the extent allowed by applicable law.

In all situations where ERISA applies the use of any ERISA-covered plan assets will be governed by applicable law, including but not limited to U.S. Department of Labor Technical Release 2011-04.

Controlling Law. This Plan shall be administered, construed, and enforced according to the federal law and the laws of the State of California, to the extent not preempted by federal law. However, with respect to a fully-insured benefit program, the applicable insurance policy or contract will control with respect to which state's laws apply.
### 14. Benefit Program Information

#### Summary of Eligibility and Participation Provisions

Note: If you have any questions about eligibility or participation, contact the Plan Administrator.

<table>
<thead>
<tr>
<th>Provider Plan Funding</th>
<th>Plan Coverage Type</th>
<th>Policy or Group #</th>
<th>Who is Eligible 1</th>
<th>When Participation Begins</th>
<th>When Participation Ends 2</th>
<th>To File a Claim, Contact:</th>
</tr>
</thead>
</table>
| Kaiser Permanente Insurance Company | Medical HMO | No. CA: 29560 So. CA: 232239 | • Regular full-time employees who work more than 30 hours per week  
• For Branch Campuses: Assistant Director, Librarian, Librarian Assistant  
• Jesuits who are members of the USF Jesuit Community  
• Employees of Fromm Institute, Loyola House, and St. Ignatius Church |  
Staff: 1st of the month following date of hire  
Jesuit: Date of hire  
Faculty: Date of hire | End of month following date of termination | Kaiser Foundation Health Plan, Inc.  
Claims Administration  
No. CA: PO Box 12923  
Oakland CA, 94604-2923  
Ph: (800) 464-4000  
So. CA: PO Box 7004  
Downey CA, 90242-7004  
Ph: (800) 464-4000 |
| Kaiser Colorado Fully-Insured | Medical HMO | 15332 | • Regular full-time employees who work more than 30 hours per week  
• For Branch Campuses: Assistant Director, Librarian, Librarian Assistant  
• Jesuits who are members of the USF Jesuit Community  
• Employees of Fromm Institute, Loyola House, and St. Ignatius Church | Staff: 1st of the month following date of hire  
Jesuit: Date of hire  
Faculty: Date of hire | End of month following date of termination | Kaiser Permanente of Colorado  
Claims Administration  
Denver/Boulder/  
Northern CO: PO Box 373150  
Denver, CO 80237  
Ph: (303) 338-3600  
Southern CO: PO Box 372910  
Denver, CO 80237  
Ph: (303) 338-3600 |
<table>
<thead>
<tr>
<th>Provider Plan Funding</th>
<th>Plan Coverage Type</th>
<th>Policy or Group #</th>
<th>Who is Eligible ¹</th>
<th>When Participation Begins</th>
<th>When Participation Ends ²</th>
<th>To File a Claim, Contact:</th>
</tr>
</thead>
</table>
| Kaiser Mid-Atlantic   | Medical HMO       | 22741            | • Regular full-time employees who work more than 30 hours per week  
                             • For Branch Campuses: Assistant Director, Librarian, Librarian Assistant  
                             • Jesuits who are members of the USF Jesuit Community  
                             • Employees of Fromm Institute, Loyola House, and St. Ignatius Church  
                         | Staff: 1st of the month following date of hire  
                             Jesuit: Date of hire  
                             Faculty: Date of hire  
                         | End of month following date of termination | Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.  
                                           PO Box 6233  
                                           Rockville, MD 20849  
                                           Ph: (888) 777-5536 |
| Anthem Blue Cross     | Medical PPO       | 13045L           | • Regular full-time employees who work more than 30 hours per week  
                             • For Branch Campuses: Assistant Director, Librarian, Librarian Assistant  
                             • Jesuits who are members of the USF Jesuit Community  
                             • Employees of Fromm Institute, Loyola House, and St. Ignatius Church  
                         | Staff: 1st of the month following date of hire  
                             Jesuit: Date of hire  
                             Faculty: Date of hire  
                         | End of month following date of termination | Customer Service  
                                           PO Box 60007  
                                           Los Angeles, CA 90060-0007  
                                           PPO: (800) 627-5342  
                                           Pharmacy: (866) 297-1013 |
| Delta Dental Insurance Company | Dental PPO | 02406            | • Regular full-time employees who work more than 30 hours per week  
                             • For Branch Campuses: Assistant Director, Librarian, Librarian Assistant  
                             • Jesuits who are members of the USF Jesuit Community  
                             • Employees of Fromm Institute, Loyola House, and St. Ignatius Church  
                         | 1st of the month following date of hire  
                         | End of month following date of termination | Delta Dental of CA  
                                           PO Box 997330  
                                           Sacramento, CA 95899-7330  
                                           Ph: (866) 499-3001 |
| Vision Service Plan   | Vision            | 12178895         | • Regular full-time employees who work more than 30 hours per week  
                             • For Branch Campuses: Assistant Director, Librarian, Librarian Assistant  
                             • Jesuits who are members of the USF Jesuit Community  
                             • Employees of Fromm Institute, Loyola House, and St. Ignatius Church  
                         | 1st of the month following date of hire  
                         | End of month following date of termination | Member Services  
                                           PO Box 997105  
                                           Sacramento, CA 95899-7105  
                                           Ph: (800) 877-7195 |
<table>
<thead>
<tr>
<th>Provider</th>
<th>Plan Funding</th>
<th>Plan Coverage Type</th>
<th>Policy or Group #</th>
<th>Who is Eligible ¹</th>
<th>When Participation Begins</th>
<th>When Participation Ends ²</th>
<th>To File a Claim, Contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONCERN</td>
<td>Fully-Insured</td>
<td>Employee Assistance Program</td>
<td>894</td>
<td>• All benefits eligible employees</td>
<td>Date of hire</td>
<td>End of month following date of termination</td>
<td>Member Services 1503 Grant Road, Suite 120 Mountain View, CA 94040 Ph: (800) 344-4222</td>
</tr>
</tbody>
</table>
| Life Insurance Company of North America (Cigna) | Fully-Insured | Basic Life/AD&D, Voluntary Life/AD&D | Life: FLX962892 AD&D: OK964555 | • Class 1: All active, part-time University of San Francisco Faculty Association faculty in the Preferred Hiring Pool and part-time Legal Research, Writing and Analysis Faculty in the School of Law, scheduled to work at least 20 hours per week  
• Class 2: All active, Full-time Employees in the United States, Philippines, El Salvador, and China scheduled to work at least 30 hours per week  
• Class 3: All active, Full-time University of San Francisco Stationary Engineers Local 39 Employees who are subject to a collective bargaining agreement. | Date of hire | Date of termination | Cigna Group Insurance 2000 Park Lane Drive North Fayette, PA 15275 Ph: (800) 362-4462 |
| Life Insurance Company of North America (Cigna) | Fully-Insured | Long-Term Disability | LK962116 | • All active, Full-time Employees working at least 30 hours per week, University of San Francisco Stationary Engineers Local 39 Employees who are subject to a collective bargaining agreement  
• Law Faculty Employees and part-time Employees working at least 20 hours per week who are classified as Counseling Psychologists, Regional Campus Librarians, Regional Campus Library Assistants, Research Assistants and Regional Campus Assistant Directors | Date of hire | Date of termination | Cigna Group Insurance 2000 Park Lane Drive North Fayette, PA 15275 (800) 362-4462 |
| National Union Fire Ins. Co. of Pittsburgh (AIG) | Fully-Insured | Business Travel Accident | GTP9128829 | • Class 1: All eligible executive employees  
• Class 2: All eligible supervisory managerial & administrative employees (including faculty members)  
• Class 3: All other eligible employees | Date of hire | Date of termination | Claims Service Center PO Box 25987 Shawnee Mission, KS 66225-5987 Ph: (800) 551-0824 |
<table>
<thead>
<tr>
<th>PROVIDER PLAN FUNDING</th>
<th>PLAN COVERAGE TYPE</th>
<th>POLICY OR GROUP #</th>
<th>WHO IS ELIGIBLE ¹</th>
<th>WHEN PARTICIPATION BEGINS</th>
<th>WHEN PARTICIPATION ENDS ²</th>
<th>TO FILE A CLAIM, CONTACT:</th>
</tr>
</thead>
</table>
| Custom Benefit Administrators Self-Funded | Flexible Spending Accounts | N/A | • Regular full-time employees who work more than 30 hours per week  
• For Branch Campuses: Assistant Director, Librarian, Librarian Assistant  
• Jesuits who are members of the USF Jesuit Community  
• Employees of Fromm Institute, Loyola House, and St. Ignatius Church | 1st of the month following date of hire | Claims must be submitted within 60 days of the date of termination. | Fax: (866) 893-8577 |
| Custom Benefit Administrators Self-Funded | SF HCSO Health Reimbursement Account | N/A | • Employees working 8 or more hours per month in the City of San Francisco who are not otherwise eligible for full-time benefits | 1st of the month following 90 days of employment | Date of termination | Custom Benefit Administrators  
PO Box 2170  
Rocklin, CA 95677  
Ph: (800) 574-5448  
Fax: (800) 584-4591 |

Notes:
1. Please consult carrier documentation for further details regarding which family members are eligible to participate in each of the above coverages. For more information on eligibility and hours calculation please refer to the following page.
2. Other Events (Such as fraud or intentional misrepresentation of a material fact) can also terminate coverage—see the benefit program details.
3. The health flexible spending account and DCAP provisions in the Section 125 plan are a part of this welfare benefit plan and summary plan description and are incorporated by reference and attached as Appendix C.
Additional Information on ACA FT Status Determination

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee who works on average 130 hours per month. ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility.

New employees hired to work full-time. If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for medical plan coverage as of 1st of the month following date of hire (Staff) or date of hire (Jesuit & Faculty).

New employees hired to work a part-time, variable hour or seasonal schedule. If you are hired into a part-time position, a position where your hours vary and University of San Francisco is unable to determine — as of your date of hire — whether you will be a full-time employee (work on average 130 or more hours a month), or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of 12 months to determine whether you are a full-time employee. Your 12-month IMP will begin on the first of the month following your date of hire and will last for 12 months. If, during your IMP, you average 30 or more hours a week over that 12 month period, you will be full time and, if otherwise eligible for benefits, you will be offered coverage by the first of the second month after your IMP ends. Your full-time status will remain in effect during an associated stability period that will last 12 months from the date that status is determined. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

Ongoing employees. University of San Francisco uses the look-back measurement method to determine medical plan eligibility for ongoing employees. An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 12-month period of time over which University of San Francisco counts employee hours to determine which employees work full-time. An employee is deemed full-time if he or she averages 130 or more hours a month over the 12-month standard measurement period. Those employees who average 130 or more hours a month over the 12-month standard measurement period will be full time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect for a 12-month stability period. If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

University of San Francisco uses the standard measurement period and associated stability period annual cycle set forth below.

<table>
<thead>
<tr>
<th>PLAN YEAR</th>
<th>MEASUREMENT PERIOD</th>
<th>ADMIN PERIOD</th>
<th>STABILITY PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 1</td>
<td>Nov 1 – Oct 31</td>
<td>Nov 1 – Dec 31</td>
<td>Jan 1 – Dec 31</td>
</tr>
</tbody>
</table>
Appendix A: COBRA Continuation

GENERAL NOTICE OF YOUR RIGHTS GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

THIS LETTER IS FOR YOUR INFORMATION ONLY. PLEASE RETAIN FOR FUTURE REFERENCE. THERE HAS NOT BEEN A CHANGE IN YOUR STATUS WITH YOUR COMPANY.

This letter contains important information about your employee benefits plan(s). Please read the entire letter.

On April 7, 1986, a federal law called COBRA was enacted (Public Law 99-272, Title X), requiring that most employers sponsoring group health plans offer employees and their families (qualified beneficiary/ies) the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights as a qualified beneficiary and obligations under COBRA. Both you and your spouse/registered domestic partner, if applicable, should take the time to read this notice carefully. This notice does not fully describe COBRA or other rights under the USF group health plan ("Group Health Plan"). For additional information you should review the Group Health Plan’s "Summary Plan Description" or contact the USF Plan Administrator at (415) 422-6075. Also, you may visit the Department of Labor website (www.dol.gov) for more information on COBRA. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

Qualifying Events

If you are an employee of USF covered by the Group Health Plan, you have a right to choose COBRA if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse/registered domestic partner of an employee covered by the Group Health Plan, you have the right to choose COBRA for yourself if you lose group health coverage under the Group Health Plan for any of the following reasons:

1. The death of your spouse/registered domestic partner;
2. A termination of your spouse/registered domestic partner’s employment (for reasons other than gross misconduct) or reduction in your spouse/registered domestic partner’s hours of employment with USF;
3. Divorce or legal separation from your spouse/registered domestic partner; or
4. Your spouse/registered domestic partner becomes entitled to Medicare.

In the case of a dependent child of an employee covered by the Group Health Plan, he or she has the right to choose COBRA if the Group Health Plan is lost for any of the following reasons:

1. The death of the employee;
2. A termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment with USF;
3. The employee’s divorce or legal separation;
4. The employee became entitled to Medicare prior to his/her qualifying event; or
5. The dependent child ceases to be a dependent child under the Group Health Plan.

Sometimes, filing a bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to USF and that bankruptcy results in the loss of coverage of any retired employee under the Group Health Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse/registered domestic partner, surviving spouse/registered domestic partner, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Group Health Plan.

You may have other options available to you when you lose group health coverage?

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse/registered domestic partner's plan), even if that plan generally doesn't accept late enrollees.

Coverage Provided

Under COBRA, the employee or a family member has the responsibility to inform the USF Plan Administrator of a divorce, legal separation, or a child losing dependent status under the Group Health Plan within 60 days of the date of the event. USF has the responsibility to notify the administrator of the employee's death, termination, and reduction in hours of employment or Medicare entitlement. When the administrator is notified that one of these events has happened, the administrator will in turn notify you that you have the right to choose COBRA. Under COBRA, you have at least 60 days from the later of the date you would lose coverage because of one of the qualifying events described above or the date of notification of your rights under COBRA, whichever is later, to inform the USF Plan Administrator that you want to continue coverage under COBRA.

If you elect COBRA, USF is required to give you and your covered dependents, if any, coverage that is identical to the coverage provided under the plan to similarly situated employees or family members. Under COBRA, you may have to pay all or part of the premium for your continuation coverage. If you do not choose COBRA on a timely basis, your group health insurance coverage will end.

Period of Coverage

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certainqualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

COBRA requires that you be afforded the opportunity to maintain coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required COBRA period is 18 months. Also, if you or your spouse/registered domestic partner gives birth to or adopts a child while on COBRA, you will be allowed to change your coverage status to include the child. The 18-month period may be extended to 29 months if an individual is determined by the Social Security Administration (SSA) to be disabled (for Social Security purposes) as of the termination or
reduction in hours of employment or within 60 days thereafter. To benefit from this extension, a qualified beneficiary must notify the USF Plan Administrator of that determination within 60 days and before the end of the original 18-month period. The affected individual must also notify the USF Plan Administrator within 30 days of any final determination that the individual is no longer disabled. If the original event causing the loss of coverage was a termination (other than for gross misconduct) or a reduction in hours, another extension of the 18-month continuation period may occur, if during the 18 months of COBRA coverage, a qualified beneficiary experiences certain secondary qualifying events:

1. Divorce or legal separation
2. Death
3. Medicare entitlement
4. Dependent child ceasing to be a dependent

If a second qualifying event does take place, COBRA provides that the qualified beneficiary may be eligible to extend COBRA up to 36 months from the date of the original qualifying event. If a second qualifying event occurs, it is the qualified beneficiary's responsibility to inform the USF Plan Administrator within 60 days of the event. In no event, however, will COBRA last beyond three years from the date of the event that originally made the qualified beneficiary eligible for COBRA.

Health FSA Information

COBRA coverage under the USF Health FSA will be offered only to Qualified Beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for the USF Health FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the USF Health FSA coverage in force at the time of the qualifying event. The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and the COBRA coverage for the FSA plan will terminate at the end of the plan year. Unless otherwise elected, all qualified beneficiaries who were covered under the USF Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact Custom Benefit Administrators, Inc. at (916) 303-7100 during business hours for more information.

Alternate Recipients Under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by USF during the covered employee's period of employment with USF is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Are there other coverage options besides COBRA Continuation Coverage

Yes. 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/registered domestic partner's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.
Plan Contact Information

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.HealthCare.gov.

To ensure that all covered individuals receive information properly and timely, it is important that you notify our Customer Service Department at (916) 303-7100 of any change in dependent status or any address change of any family member as soon as possible. Certain changes must be submitted to us in writing. Failure on your part to notify us of any changes may result in delayed notification or loss of continuation of coverage options.

If you have any questions about COBRA, please contact our Customer Service Department at (916) 303-7100 during business hours.

Sincerely,

Custom Benefit Administrators, Inc.

USF HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT WAIVER OF ENROLLMENT NOTIFICATION REVISED 11/97

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you and/or your dependents, if any, waive coverage due to coverage under another plan, and desire to participate in the plan offered at a later date, coverage may be subject to treatment as a late enrollee. If you decline enrollment for yourself or your dependents (including your spouse/registered domestic partner), you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after such marriage, birth of a child or placement of a child for adoption.

PRE-EXISTING CONDITION EXCLUSION

A pre-existing condition is an injury or sickness which was diagnosed or treated or for which prescription medications or drugs were prescribed or taken within the six months ending on the person's date of hire. A pre-existing condition does not include pregnancy or apply to newborn children or newly adopted children. To shorten or eliminate the period of time during which the pre-existing condition applies, you have the right to provide evidence of continuous creditable coverage. Any or all of the plans that provide prior coverage must give you a Certificate of Creditable Coverage. If necessary, the insurance carrier of this employer will assist in obtaining this certificate from the prior coverage. You will be notified of any pre-existing condition exclusion period, if one applies, upon receipt of a Certificate of Creditable Coverage. Limited or no coverage is provided for eligible expenses which result from a pre-existing condition until the earlier of the date you have had continuous creditable coverage for a period of six consecutive months and have not received treatment for the pre-existing condition or the date you have had continuous creditable coverage for 12 months. (NOTE: Under the Affordable Care Act, a group health plan must eliminate any pre-existing condition limitations as of the first day of the plan year that begins in 2014.)
CERTIFICATE OF CREDITABLE COVERAGE
If you have a Certificate of Creditable Coverage you should attach it to your enrollment form and submit it to your group administrator for processing. If you receive the certificate after submitting your enrollment form, please forward it to your group administrator at your first opportunity.

If you have any questions about COBRA, please contact our Customer Service Department at (916) 303-7100 during business hours.

Sincerely,

Custom Benefit Administrators, Inc.
Appendix B: Medicare Part D

Important Notice from University of San Francisco About Your Prescription Drug Coverage and Medicare Kaiser HMO, Anthem Blue Cross PPO

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with University of San Francisco and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. University of San Francisco has determined that the prescription drug coverage offered by the University of San Francisco Welfare Benefit Plan, specifically — the Kaiser HMO and Anthem Blue Cross PPO is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your University of San Francisco coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under University of San Francisco Welfare Benefit Plan is creditable (e.g. as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.
If you do decide to join a Medicare drug plan and drop your University of San Francisco prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

**When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**
You should also know that if you drop or lose your current coverage with University of San Francisco and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.
If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

**For More Information About This Notice Or Your Current Prescription Drug Coverage...**
Contact the person listed below for further information. **NOTE:** You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through University of San Francisco changes. You also may request a copy of this notice at any time.

**For More Information About Your Options Under Medicare Prescription Drug Coverage...**
More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

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<th>Date:</th>
<th>January 1, 2015</th>
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<td>University of San Francisco</td>
</tr>
<tr>
<td>Contact--Position/Office:</td>
<td>Director of Employee Benefits</td>
</tr>
<tr>
<td>Address:</td>
<td>2130 Fulton St., San Francisco, CA 94117</td>
</tr>
<tr>
<td>Phone Number:</td>
<td>1-415-422-2442</td>
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Appendix C: Cafeteria Plan and FSA Provisions

UNIVERSITY OF SAN FRANCISCO
FLEXIBLE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

January 1, 2015

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Custom Benefit Administrators, Inc.
### UNIVERSITY OF SAN FRANCISCO FLEXIBLE BENEFIT PLAN

### SUMMARY PLAN DESCRIPTION

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INTRODUCTION

University of San Francisco (the "Company") established the University of San Francisco Flexible Benefit Plan (the "Plan") effective January 1, 1998. This Summary Plan Description describes the Plan as amended and restated effective August 1, 2014.

This revised Summary Plan Description supersedes all previous Summary Plan Descriptions. Although the purpose of this document is to summarize the more significant provisions of the Plan, the Plan document will prevail in the event of any inconsistency.

ELIGIBILITY FOR PARTICIPATION

Eligible Employee

You are an "Eligible Employee" if you are employed by University of San Francisco or any affiliate who has adopted the Plan. However, you are not an "Eligible Employee" if you are any of the following:

A self-employed individual (including a partner), or a person who owns (or is deemed to own) more than 2 percent of the outstanding stock of an S corporation.

A leased employee.

A non-resident alien who received no U.S. earned income.

A part-time employee who is expected to work fewer than 20 hours per week.

The term "Eligible Employee" is further modified as follows: Regular Full-Time Employees scheduled to work more than 30 hours per week. Also eligible to enroll if you are a Branch Campus Assistant Director, Branch Campus Librarian, Branch Campus Library Assistant, or a staff member participating in the USF Voluntary Reduction in Time (VRT) Program scheduled to work at least 20 hours per week. In addition, you are eligible if you are a Jesuit member of the USF Jesuit Community or an otherwise eligible employee of the Fromm Institute, Loyola House, or St. Ignatius Church.

You are an "Eligible Employee" for purposes of the Premium Conversion Account on the date you become eligible to receive benefits from the contracts described for Premium Conversion Accounts in the Section titled "BENEFITS" below; but only if you are not a self-employed individual (including a partner) and you are not a person who owns (or is deemed to own) more than 2 percent of the outstanding stock of an S corporation.

Date of Participation

You will become a Participant eligible to receive benefits from the Plan on the first day of the calendar month next following the date you first perform an hour of service as an Eligible Employee.

However, you will become a Participant eligible to make contributions and receive benefits from the Premium Conversion Account on the date you become eligible to receive benefits from the contracts described for Premium Conversion Accounts in the Section titled "BENEFITS" below.

You will stop being a participant eligible to receive benefits from the Plan on the date you are no longer an Eligible Employee or the date you terminate employment with the Company.

ELECTIONS

In General
When you become eligible to participate in the Plan, you may begin contributing to the Plan. All contributions will be credited to an account established in your behalf. Your contributions to the Plan are not subject to federal income tax or social security taxes.

Please note that while you may enjoy certain tax benefits, there may be some drawbacks to participation in the Plan. For instance, participation in the Plan may lower your social security benefits. You should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

**Election Procedures**

When you are first eligible to participate in the Plan, you must make an election on or before the date specified by the Plan Administrator.

After you are first eligible to participate in the Plan you will generally only be able to change your elections as of the beginning of each Plan Year. Prior to the start of each Plan Year, the Plan Administrator will provide an election form to you. In order to participate in the Plan for the next Plan Year, you must return the completed election form to the Plan Administrator on or before the date specified by the Plan Administrator. However, see "Modification of Elections" below for situations where you may modify elections at a time other than the beginning of a Plan Year.

If, as of the start of a Plan Year, you have not returned an election form by its due date, you will be deemed to have elected not to participate in the Plan for that Plan Year.

As of the start of every Plan Year, you are deemed to elect to contribute the entire amount of any participant-paid premiums for the Premium Conversion Account unless you otherwise elect in writing.

**Modification of Elections**

Generally speaking, you may only revise your elections as of the start of a Plan Year. However, in certain situations you may modify your elections upon a "change in status". A brief listing of events that constitute a change in status follows. Please note that there are several conditions and/or limitations that apply to the events listed below. Please contact the Plan Administrator if you have any questions or believe that you may qualify for an election change. A change in status includes:

- Change in your marital status.
- Change in the number of your dependents.
- Change in employment status.
- A dependent satisfies or ceases to satisfy eligibility requirements.
- Change in your place of residence.
- Commencement or termination of an adoption proceeding.
- Court judgment, decree, or order.
- Entitlement to Medicare or Medicaid.
- Significant cost or other coverage changes.
- You take leave under the FMLA.

If you have a change in status, you may modify an election in your Health Care Reimbursement Account but your new annual contribution amount may not be less than the amount previously reimbursed at the time of the election change.

You are permitted to revoke an election of coverage under a group health plan due to reduction in hours of service. In order to revoke an election of coverage under a group health plan due to reduction in hours of service, you must have been
in an employment status under which you were reasonably expected to average at least 30 hours of service per week and there is a change in your status so that you will reasonably be expected to average less than 30 hours of service per week after the change. In addition, your revocation of the election of coverage under the group health plan must correspond to your intended enrollment (and any related individuals who cease coverage due to the revocation) in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

You are permitted to revoke an election of coverage under a group health plan due to enrollment in a qualified health plan offered through the Health Insurance Marketplace. In order to revoke an election of coverage under a group health plan due to enrollment in a qualified health plan offered through the Health Insurance Marketplace, you must be eligible for a special enrollment period to enroll in a qualified health plan through the marketplace or during the marketplace's annual enrollment period. In addition, the revocation of the election of coverage under the group health plan must correspond to your intended enrollment (and any related individuals who cease coverage due to the revocation) in a qualified health plan through a marketplace for new coverage that is effective no later than the day immediately following the last day of the original coverage that is revoked.

In addition, your election for your premiums will be automatically adjusted for any change in the cost of contracts as permitted by applicable law.

**BENEFITS**

**Premium Conversion Account**

When you become eligible to participate in the Plan, the Plan will establish a Premium Conversion Account in your name. This Account will be credited with your contributions and will be reduced by any payments made on your behalf. This account may be used to pay premiums on the contracts listed below:

- Employer Group Medical
- Employer Dental
- Employer Vision

If a contract is offered in conjunction with a Company-sponsored benefit plan, you will be eligible to make contributions to the Premium Conversion Account only if you are also eligible to participate in the applicable Company-sponsored plan. It is described above and you are eligible to participate in this Plan.

In the event of a conflict between the terms of this Plan and the terms of a contract, the terms of the contract (or the benefit plan under which it is established) will control.

**Health Care Reimbursement Account**

When you become eligible to participate in the Plan, the Plan will establish a Health Care Reimbursement Account in your name. This Account will be credited with your contributions and will be reduced by any payments made on your behalf. You will be entitled to receive reimbursement from this account for eligible expenses incurred by you, your spouse and dependents, if any. A dependent is generally someone who you may claim as a dependent on your federal tax return and also includes a child who is under the age of 27 through the end of the calendar year. You may receive reimbursement for eligible expenses incurred at a time when you are actively participating in the Plan.

The entire annual amount you elect to contribute for the Plan Year for the Health Care Reimbursement Account less any reimbursements already disbursed will be available for reimbursement. The maximum amount you may contribute each year is the maximum amount permitted ($2,500 for 2014, subject to change for 2015).

Eligible expenses generally include all medical expenses that you may deduct on your federal income tax return, although health insurance premiums are not an eligible expense for the Health Care Reimbursement Account. Medicines or drugs are eligible expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin (unless otherwise excluded). You will not be reimbursed for any
expenses that are (i) not incurred in the Plan Year, (ii) incurred before or after you are eligible to participate in the Plan, (iii) attributable to a tax deduction you take in a prior taxable year, or (iv) covered, paid or reimbursed from any other source.

**Dependent Care Assistance Account**

When you become eligible to participate in the Plan, the Plan will establish a Dependent Care Assistance Account in your name. This Account will be credited with your contributions and will be reduced by any payments made on your behalf. You will be entitled to receive reimbursement from this account for dependent care assistance. Dependent care assistance is defined as expenses you incur for the care of a qualifying individual. A qualifying individual is a dependent who is under age 13 or a spouse or dependent who lives with you and is physically or mentally incapable of caring for himself/herself. However, these expenses only qualify if they allow you to be gainfully employed.

Not all expenses qualify as dependent care assistance. Only expenses that are excludable from income under federal tax may qualify as dependent care assistance. Some examples of expenses that qualify are:

- Before and after school programs
- Care in your home or someone else's home (as long as the care giver is not your spouse or dependent and is age 19 or older)
- Licensed child care center
- Nursery school or pre-school
- Summer day care (not overnight)

Please contact the Plan Administrator before enrolling in the Plan to confirm that the expenses for which you will seek reimbursement will qualify as dependent care assistance.

You will not be reimbursed for any expenses that are (i) not incurred in the Plan Year, (ii) incurred before or after you are eligible to participate in the Plan, (iii) attributable to a tax credit you take for the same expenses, or (iv) covered, paid or reimbursed from any other source.

The maximum amount of expense that may be contributed/reimbursed in any Plan Year is $5,000 ($2,500 if you are married and filing a separate return). The amount payable may also not be greater than the amount of your earned income or the earned income of your spouse. Special rules apply in the case of a spouse who is a student or incapable of caring for himself/herself.

You generally must file a Form 2441 to determine whether any part of your Dependent Care Assistance Account is taxable. Please note that participation in the Plan may prevent you from taking a tax credit for the same expenses. You should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

**Coordination with Other Plans**

All claims for benefits that are covered by an insurance policy must be made to the insurance company issuing such insurance policy.

**Limits on Certain Employees**

If you are a highly paid employee or an owner of the Company, federal law may impose limits on your eligibility to participate in the Plan and/or the benefits you may receive from the Plan.

**COMPANY CONTRIBUTIONS**

**Amount**

The Company will make a contribution to help fund one or more of your accounts. The method used to determine the contribution and the method used to allocate the contribution is as follows: You will receive the cash-in-lieu benefits
bonus if you voluntarily waive coverage under the employer's group medical insurance plan. You must also retain other comprehensive health insurance to be eligible for the bonus and recertify for this bonus each year.

**Election to Receive Cash**

You may make an election to have the Company contribution described above be paid to you rather than having the contribution credited to your account. The election is subject to the following terms and conditions: You are permitted as an eligible employee to receive cash-in-lieu of electing coverage under the employer's group medical insurance plan. If elected, this "cash-in-lieu-of-benefits" bonus will be paid to you as taxable compensation on a pro-rata basis throughout the plan year. The amount of this bonus will be communicated separately by the employer and may change from year to year. Any election to receive the contribution paid in cash must be returned to the Plan Administrator by the date specified on the form.

**FORFEITURES**

**Plan Year/Termination**

Any amounts remaining in your account at the end of the Plan Year will be forfeited after all claims are paid. In addition, any balance remaining in your account on the date you terminate employment with the Company will be forfeited after all claims are paid.

**Grace Period**

However, the unused balance in your Medical FSA that remains at the end of a Plan Year may be used for expenses that you incur during the grace period. The grace period is the 2-1/2 month period after the end of the Plan Year.

**CLAIMS**

**Deadlines**

You must submit claims for reimbursement by March 31. However, if you terminate employment you must submit claims for reimbursement within 60 days after your date of termination.

However, the unused balance in your Medical FSA that remains at the end of a Plan Year may be used for expenses that you incur during the grace period. The grace period is the 2-1/2 month period after the end of the Plan Year. You must submit claims incurred during the grace period for reimbursement by March 31.

**Debit/Credit Cards**

The Company will provide you with a debit, credit or other stored-value card for purposes of making purchases that may be reimbursed from your Health Care Reimbursement Account. The Plan Administrator may provide you with more information about stored value cards at the time you enroll in the Plan. The following restrictions apply to the use of such card: Two debit cards will be provided to each Health Care Reimbursement Account (Health FSA) participant at no cost. Participants may be permitted to order a third or replacement debit card. A nominal fee may be deducted from the participant's Reimbursement Account balance when a third debit card is ordered, and/or when a new debit card is ordered to replace a lost or stolen card (refer to your enrollment materials for details about these charges). Any time the debit card is used, the administrator may require the participant to provide documentation to support the purchase. Should the participant not provide the required documentation in a timely manner, the claim will be denied and the participant will be required to repay the expense or, alternatively, the participant may choose to offset the expense with new expenses. Should the participant not repay the expense in a timely manner, the debit card may be suspended without further notification. In general, supporting documentation will be required for all debit card transactions with the exception of the following: (1) OTC medical supplies purchased at a retailer or pharmacy; (2) health plan co-payments; and, (3) recurring (ongoing) charges. The administrator will notify the participant whenever documentation is required. The debit card cannot be used to pay for day care expenses under the Dependent Care Assistance Account or individually owned health insurance through the Premium Reimbursement Account (if provided).
Documentation of Claims

Any claim for benefits must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merits of the claim. The Plan Administrator may request any additional information necessary to evaluate the claim.

Method and Timing of Payment

To the extent that the Plan Administrator approves a claim, the Company may either (i) reimburse you, or (ii) pay the service provider directly. The Plan Administrator will pay claims at least once per year. The Plan Administrator may provide that payments/reimbursements of less than a certain amount will be carried forward and aggregated with future claims until the reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments/reimbursements outstanding at the end of the Plan Year will be reimbursed without regard to the minimum payment amount.

Where to Submit Claims

All claims must be submitted to Custom Benefit Administrators, Inc. at P.O. Box 2170, Rocklin, CA 95677. The telephone number is 800-574-5448; Fax 800-584-4591.

Refunds/Indemnification

You must immediately repay any excess payments/reimbursements. You must reimburse the Company for any liability the Company may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

Beneficiary

If you die, your beneficiaries or your estate may submit claims for Eligible Expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose. If you do not name a beneficiary, the Plan Administrator may pay any amount to your spouse, one or more of your dependents or a representative of your estate.

Claim Procedures for Health Benefits

Application for Benefits. You or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim must be in writing and must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA, and (5): (A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline,
protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied
upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided
free of charge to the Claimant upon request; or (B) if the adverse benefit determination is based on a medical necessity or
experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the
determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation
will be provided free of charge upon request.

Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan
Administrator on or before the 180th day after he receives the Plan Administrator's notice that the claim has been wholly or
partially denied. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based.
The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. An
appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan
Administrator shall consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the
denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the
appeal, the Plan Administrator shall:

(1) Provide for a review that does not afford deference to the initial adverse benefit determination and
that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit
determination that is the subject of the appeal, nor the subordinate of such individual;

(2) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or
in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is
experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a
health care professional who has appropriate training and experience in the field of medicine involved in the medical
judgment;

(3) Provide for the identification of medical or vocational experts whose advice was obtained on
behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was
relied upon in making the benefit determination; and

(4) Provide that the health care professional engaged for purposes of a consultation under Subsection
(2) shall be an individual who is neither an individual who was consulted in connection with the adverse benefit
determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by
the Plan of the Claimant's request for review of an adverse benefit determination. The Claimant shall lose the right to appeal
if the appeal is not timely made.

Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with
a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based,
(3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of,
all documents, records, and other information relevant to the Claimant's claim for benefits, and (4) a statement describing the
Claimant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator
shall be binding upon all parties.

Claim Procedures for Non-Health Benefits

Application for Benefits. You or any other person entitled to benefits from the Plan (a "Claimant") may apply for
such benefits by completing and filing a claim with the Plan Administrator. Any such claim must be in writing and must
include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to
make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information
necessary to evaluate the claim.

Timing of Notice of Denied Claim. The Plan Administrator shall notify the Claimant of any adverse benefit
determination within a reasonable period of time, but not later than 90 days after receipt of the claim. This period may be
extended one time by the Plan for up to 90 days, provided that the Plan Administrator both determines that such an extension
is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 90-
day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a written notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, and (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA.

Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied. The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. A written appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. The Claimant shall lose the right to appeal if the appeal is not timely made. The Plan Administrator shall ordinarily rule on an appeal within 60 days. However, if special circumstances require an extension and the Plan Administrator furnishes the Claimant with a written extension notice during the initial period, the Plan Administrator may take up to 120 days to rule on an appeal.

Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (4) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator shall be binding upon all parties.

CONTINUATION RIGHTS

Military Service

If you serve in the United States Armed Forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

COBRA

Under Federal law, you, your spouse, and your dependents may be entitled to COBRA continuation coverage in certain circumstances. Please see the "COBRA NOTICE" that is attached to the end of this Summary Plan Description for important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The COBRA NOTICE generally explains COBRA continuation coverage and when it may become available to you. The Plan Administrator will inform you of these rights, if any, when you terminate employment.

FMLA

If you go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving health care benefits.

You may elect to continue coverage on a pre-tax or after tax basis for non medical benefits when on leave of absence under the FMLA.

Non FMLA Leave

In addition, you may elect to continue coverage on a pre-tax or after tax basis when on leave of absence other than the FMLA.
YOUR RIGHTS UNDER ERISA

As a participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). This federal law provides that you have the right 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 insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration if a 5500 is required to be filed by the plan.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, 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. 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, spouse or 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 this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

In addition, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the 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 or exercising your rights under ERISA.

If your claim for a 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. 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 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, 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 the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 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.

MISCELLANEOUS

Qualified Medical Child Support Orders
In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO). You may obtain a copy of the QMCSO procedures from the Plan Administrator, free of charge.

**Loss of Benefit**

You may lose all or part of your account if the unused balance is forfeited at the end of a Plan Year and if we cannot locate you when your benefit becomes payable to you.

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a Beneficiary.

**Amendment and Termination**

The Company may amend, terminate or merge the Plan at any time.

**Administrator Discretion**

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding.

**Taxation**

The Company intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, the Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

**Privacy**

The Plan is required under federal law to take sufficient steps to protect any individually identifiable health information to the extent that such information must be kept confidential. The Plan Administrator will provide you with more information about the Plan's privacy practices.

**ADMINISTRATIVE INFORMATION**

1. The Plan Sponsor and Plan Administrator is University of San Francisco.
   
   Its address is 2130 Fulton Street LMM 339, San Francisco, California 94117.
   
   Its telephone number is 415-422-2442.
   
   Its Employer Identification Number is 94-1156628.

2. The Plan is a welfare benefit plan which has been designated by the sponsor as its plan number 501.

3. The Plan's designated agent for service of legal process is the chief officer of the entity named in paragraph 1. Any legal papers should be delivered to him or her at the address listed in paragraph 1. However, service may also be made upon the Plan Administrator.

4. The Company's fiscal year ends on May 31 and the plan year ends on December 31.
Addendum

SUPPLEMENTAL INFORMATION PERTAINING TO THE SECTION TITLED "METHOD AND TIMING OF PAYMENT" UNDER "CLAIMS":

This section refers to traditional claims filed with the administrator using a claim form or by using the online claims filing feature. This section does not pertain to claims paid using a debit card (if applicable). Approved claims will be paid twice weekly on Wednesday and Friday (excluding administrator holidays). The cut off for the administrator to receive a claim is noon (Pacific Time Zone) on the previous day. For instance, claims received by the administrator prior to noon on Tuesday will be paid (if approved) on Wednesday. Currently, there is no minimum reimbursement amount imposed by the administrator. All claims submitted will be paid in accordance with this schedule (if otherwise approved), regardless of the amount requested. However, the administrator may choose to impose a minimum reimbursement amount in the future. Should a minimum reimbursement amount be imposed, it will be communicated to participants during the enrollment period that proceeds each new plan year. Currently, the administrator will not pay reimbursements directly to the service provider. Reimbursements may only be paid directly to the participant. In most cases, the participant may decide to receive reimbursements via check or direct deposit into their personal bank account (some plans limit reimbursements to direct deposit).
COBRA NOTICE

In General.

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
The parent-employee's employment ends for any reason other than his or her gross misconduct;

The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

The parents become divorced or legally separated; or

The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to the Company at 2130 Fulton Street LMM 339, San Francisco, California 94117. The Company's telephone number is 415-422-2442.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

The COBRA continuation coverage lasts only until the end of the plan year in which the qualifying event occurs. COBRA continuation coverage may only be elected under this plan if, as of the date of the qualifying event, the maximum benefit available under the plan for the remainder of the plan year is more than the maximum amount that the Plan could require as payment to maintain coverage for the remainder of that plan year.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.
Plan Contact Information

Director of Employee Benefits
2130 Fulton Street LMM 339
San Francisco, California 94117
415-422-2442.

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