

University of San Francisco

Welfare Benefits Plan

Master Summary Plan Description

Restated Effective January 1, 2026

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" means accidental death and dismemberment insurance.

"Affordable Care Act" means the Patient Protection and Affordable Care Act, as amended.

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

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

"Company" means University of San Francisco or any successor thereto, and any affiliated entity within the same controlled group, as that term is defined under section 414(b) of the Internal Revenue Code, that participates in the plan.

"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. It is not subject to ERISA.

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

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

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

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

"Plan" means the University of San Francisco 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 15.

"Plan Administrator" means the Company.

"SPD" means the Summary Plan Description required by ERISA § 102 summarizing this Plan and includes this document, information booklets supplied by insurance carriers, and other benefits descriptions provided to participants with this document or at any other period as appropriate to provide updates to the document, such as during open enrollment.

"WHCRA" means the Women's Health and Cancer Rights Act of 1998, as amended.

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 15. See Section 15 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 15.

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 15 constitutes the wrap Summary Plan Description as required by ERISA § 102.

3. General Information about the Plan

Plan Name:	University of San Francisco Welfare Benefits Plan.
Type of Plan:	Welfare plan providing coverages listed in Section 15. The Plan also includes funding through a cafeteria plan under Code § 125.
Plan Year:	January 1 to December 31.
Plan Number:	501
Effective Date:	January 1, 1998. The Plan has been amended several times since its original effective date, most recently as of January 1, 2023.
Funding Medium and Type of Plan Administration:	<p>Some benefits under the Plan are self-funded, and some are fully-insured. See Section 15 for a description of the benefit programs and whether they are self-funded or fully-insured.</p> <p>For benefit programs which are fully-insured, benefits are insured under a group contract entered into between the Company and insurance companies or HMO.</p> <p>The insurance companies and/or HMO, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the insurance companies and/or HMO for administering these program benefits, as described below.</p> <p>For benefit programs which are self-funded, the Company is responsible for processing and paying appropriate claims. The</p>

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 15. Reclassification from non-employee to employee status by a court or any agency or by the Company will not create any retroactive right to coverage.

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 15. You must follow any required enrollment procedures. **Always make sure 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

Section 15 describes whether your spouse and or child can participate in a particular benefit program. Section 15 also describes 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). For specifics on eligibility for each benefit offered refer to Section 15. Note that the definition of dependent may be different for the different benefits offered under the Plan.

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 the 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 15.

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) 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 acquire 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) 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), and you or a dependent later becomes eligible for state “premium 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 of absence under the same terms as active employees. When wages continue during such a leave, your contributions will 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.

Terms of Participation

Your participation and the participation of your spouse 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 15 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 15 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 to 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 15. 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 continuation coverage 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 15.

For the Health FSA benefit program, COBRA continuation coverage is available if your account is underspent (if the COBRA premium for the account (the monthly salary reduction election + 2%) for the remainder of the coverage period is less than the account's balance) but generally 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 Contribution

The Plan provides you and your eligible spouse and dependents with the benefit programs listed in Section 15. 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;
- Protheses; 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

Lifetime or annual limit on the dollar value of “essential health benefits” are no longer permitted under the major medical plans offered by the Plan. For more information on “essential health benefits” refer to the terms of policies and benefit program materials listed in Section 15. 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. Grandfathered 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 Hawaii 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 (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.

Access to Primary Care Physicians

The Affordable Care Act generally allows participants the right to designate any primary care provider who participates in the network and who is available to accept the participant and his or her family members. If the benefit program requires that a primary care provider be designated, but one is not designated, the benefit program or a health insurance issuer will designate one until the participant or family member makes such a designation.

- For children, you may designate a pediatrician as the primary care provider.
- You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

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 15, 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 and dependents) will cease when your participation in the Plan terminates. See Section 15. 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

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.

11. No Assignment

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.

Specifically, participants and beneficiaries covered under this plan cannot assign their rights to medical providers to pursue direct payment of claims either as the participant or beneficiaries' agent or under power of attorney. Under the terms of this plan, medical providers cannot take action enforcing a patient's right to recover benefits under ERISA or assert any claims under ERISA on behalf of patients, even where the patient(s) have assigned their rights to their medical providers.

12. Claims Procedure

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 or 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.

The Role of Authorized Representatives

Under ERISA and the ACA participants and beneficiaries have the right to designate an Authorized Representative for certain purposes. These purposes are generally limited to requesting documents or other information on behalf of a participant or beneficiary or acting on their behalf during claims and appeals procedures that can follow an adverse benefits determination. In any situation that does not constitute an urgent care claim, to designate any third party as an Authorized Representative a participant or beneficiary must use the signed statement included as an appendix of this document with the required witness signature. A medical provider will not become a participant or beneficiary's Authorized Representative as a result of an attempt to secure an assignment of benefits. The Plan does not guarantee that any purported assignment will be valid under the terms of the Plan.

13. 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, 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.

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.

14. 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, or the common fund doctrine. The plan's right to full recovery is not reduced if settlement funds or other payments to you are spent or no longer in an individual's possession or control. 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:

- Considered an asset of the Company, not the Plan. The Company does not need to use such a rebate to benefit Employees, participants or beneficiaries. The Company can use such a rebate for the Company's own purposes
- 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.
- The entire amount shall be an asset of the Plan, to be used for the benefit of individuals covered by the Plan.

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.

15. Benefit Program Information

Summary of Eligibility and Participation Provisions

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

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends¹	To File a Claim, Contact:
Medical	Fully-Insured / Kaiser Permanente	N. CA: 29560 S. CA: 232239 Hawaii: 17937	Full time employees and employees of the Fromm Institute working 30+ hours per week.	Staff: 1 st of the month following date of hire Faculty: Date of hire	At the end of the month following date of termination.	Kaiser Foundation Health Plan, Inc. Claims Administration N. CA: PO Box 12923 Oakland CA, 94604-2923 Ph: (800) 464-4000 S. CA: PO Box 7004 Downey CA, 90242-7004 Ph: (800) 464-4000 Hawaii: P.O. Box 378021 Denver, CO 80237 Ph: (800) 966-5955
Medical	Self-Funded / Anthem Blue Cross	PPO: 13051S HDHP: 13051Y Retiree: 13051X	Active: Full time employees and employees of the Fromm Institute working 30+ hours per week. Retiree: Pre-65 Retiree Healthcare Coverage allows	Staff: 1 st of the month following date of hire Faculty: Date of hire	At the end of the month following date of termination.	Customer Service PO Box 60007 Los Angeles, CA 90060-0007 PPO: (800) 627-5342 Pharmacy: (866) 297-1013

¹ Other Events (such as fraud or intentional misrepresentation of a material fact) can also terminate coverage -- see the benefit program details.

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends¹	To File a Claim, Contact:
			eligible retiring employees aged between 60 and 65 to continue their current enrollments in USF health plan coverage (i.e. medical, dental, vision, and EAP) upon retiring. Retirees are responsible for paying 100% of the premiums. A retiree must have been a full-time USF employee for at least ten (10) consecutive years immediately prior to their retirement to be eligible to enroll in Pre-65 Retiree Healthcare Coverage, unless their Collective Bargaining Agreement states otherwise.			
Dental	Self-Funded / Delta Dental	02406	Full time employees and employees of the Fromm Institute working 30+ hours per week.	1 st of the month following date of hire	End of the month following date of termination.	Delta Dental of CA PO Box 997330 Sacramento, CA 95899-7330 Ph: (866) 499-3001
Vision	Fully-Insured / VSP	12178895	Full time employees and employees of the Fromm Institute working 30+ hours per week.	1st of the month following date of hire Jesuits: 1 st of month following date of hire through USF	End of month following date of termination	Member Services PO Box 997105 Sacramento, CA 95899-7105 Ph: (800) 877-7195
EAP	Fully-Insured / Concern	894	All benefits eligible employees.	Date of hire	End of month following date of termination	Member Services 1503 Grant Road, Suite 120 Mountain View, CA

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends¹	To File a Claim, Contact:
						94040 Ph: (800) 344-4222
Business Travel Accident	Fully-Insured / AIG	GTP 000912882 9-C	Full time employees working 30+ hours per week.	Date of hire	Date of termination	Claims Service Center PO Box 25987 Shawnee Mission, KS 66225-5987 Ph: (800)551-0824 Aandh.claimssubmissions@aig.com
FSA	Fully-Insured / BRI	N/A	Full time employees and employees of the Fromm Institute working 30+ hours per week.	1 st of the month following date of hire	Claims must be submitted within 60 days of the date of termination.	Customer Service Ph: (800)473-9595 info@benefitresouce.com
Basic Life and AD&D; Voluntary Life and AD&D	Fully-Insured / New York Life	Life: FLX 962892 AD&D: OK 964555	<ul style="list-style-type: none"> • Class 1: All active University of San Francisco Adjunct Faculty Association Employees working in the United States scheduled to work at least 20 hours per week. • Class 2: All active, Full-time Employees in the United States working 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. 	Basic Life and AD&D: Date of hire Voluntary Life and AD&D: 1 st of the month following date of hire	Date of termination	New York Life 2000 Park Lane Drive North Fayette, PA 15275 Ph: (800)362-4462
LTD	Fully-Insured / New York Life	LK 962116	• All active, Full-time Employees including those classified as Local Engineers,	Date of hire	Date of termination	New York Life 2000 Park Lane Drive

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends ¹	To File a Claim, Contact:
			who are subject to a bargaining agreement and working in the United States, scheduled to work at least 30 hours per week.			North Fayette, PA 15275 Ph: (800)362-4462

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 group medical plan coverage as of the 1st of the month following date of hire (Staff) or date of hire (USFFA Faculty and Librarians).

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 130 or more hours a month 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 [group health /medical/health] 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.

Plan Year	Measurement Period	Admin Period	Stability Period
Jan 1	Nov 1 – Oct 31	Nov 1 – Dec 31	Jan 1 – Dec 31

Appendix A: COBRA Continuation

Cal-COBRA Continuation Coverage for Certain California Insured Plans

Insured medical plans with Contracts based in California are required to offer COBRA-qualified beneficiaries who are enrolled in their plans and exhaust their 18 or 29 months of federal COBRA an additional period of continuation coverage for a combined total of 36 months of continuation coverage from the date federal COBRA began. The premium charged for this additional coverage (after the maximum COBRA period has expired) will generally be 110% of the current premium rate. Contact your insurance carrier for further information on Cal-COBRA. Your insurance carrier will be able to supply you with further information regarding how to enroll, deadlines for enrollment, premium amounts, and deadlines for submitting premiums.

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 University of San Francisco;
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 University of San Francisco 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, surviving spouse, 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's plan), even if that plan generally doesn't accept late enrollees.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

How Long Does COBRA Coverage Last?

COBRA coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive up to a maximum of 36 months of coverage under the Plan's Medical and Dental components. These "36-month events" include the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan's Medical and Dental component for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage under the Plan's Medical and Dental components generally can last for only up to a total of 18 months.

COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred - see the paragraph below entitled "Health FSA Information".

The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage periods described in this notice for several reasons, which are described in the Plan's summary plan description.

There are also ways (described in the following paragraphs) in which the period of COBRA coverage resulting from a termination of employment or reduction of hours can be extended. (The period of COBRA coverage under the Health FSA cannot be extended under any circumstances.)

Coverage Provided

Under COBRA, the employee or a family member has the responsibility to inform the University of San Francisco 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. University of San Francisco 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 University of San Francisco Plan Administrator that you want to continue coverage under COBRA. If these procedures are not followed or if the notice is not provided during the 60-day notice period, then all qualified beneficiaries will lose their right to elect COBRA.

If you elect COBRA, University of San Francisco 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. Certain qualifying 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 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 University of San Francisco 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 University of San Francisco Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

The disability extension is available only if you notify in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

1. the date of the Social Security Administration's disability determination;
2. the date of the covered employee's termination of employment or reduction of hours; and
3. the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

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 University of San Francisco Plan Administrator within 60 days of the event or there will be no extension of COBRA coverage. 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. This extension may be available to the spouse and any dependent children getting COBRA coverage if the employee or former employee dies; gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

Health FSA Information

COBRA coverage under the University of San Francisco 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 University of San Francisco Health FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the University of San Francisco 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 University of San Francisco 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 University of San Francisco Administrators at (415)422-2442 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 University of San Francisco during the covered employee's period of employment with University of San Francisco 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'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 <https://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 (800)473-9595 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 (800)473-9595 during business hours.

Sincerely,

Benefit Resource Inc

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), 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.

If you have any questions, please contact our Customer Service Department at (800)483-9595 during business hours.

Sincerely,

Benefit Resource Inc

Appendix B: Medicare Part D

Important Notice from University of San Francisco About Your Prescription Drug Coverage and Medicare

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 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 can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 Human Resources Benefit Team 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 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 800-MEDICARE (800-633-4227). TTY users should call 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 socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

	Kaiser		Anthem Blue Cross PPO	
	In-Network Only	In-Network	Out-of-Network	
Generic	\$10 copay	\$10 copay	\$10 copay plus 50% of the maximum amount allowed	

Brand-name: Formulary	\$20 copay	\$20 copay	\$20 copay plus 50% of the maximum amount allowed
Brand-name: Non-Formulary	All drugs on formulary	\$25 copay	\$25 copay plus 50% of the maximum amount allowed
Supply	Up to 100-day maximum supply	30-day (Retail) or 31-day to 90-day (Mail Order) maximum supply	30-day to 90-day maximum supply

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).

Date: January 1, 2026
Name of Entity/Sender: University of San Francisco
Contact-Position/Office: The Human Resources Benefits Team
Address: 2130 Fulton Street, San Francisco, CA 94117-1080
Phone Number: (415) 422-2442
Email: benefits@usfca.edu

Appendix C: Cafeteria Plan and FSA Provisions

FLEXIBLE BENEFIT PLAN

featuring Beniversal®

Plan Document

*Effective 01.01.2021
Revised 12.2021*



1. PRELIMINARY MATTERS

1.1 *Form.* The Flexible Benefit Plan is set forth in this document, the accompanying Plan Highlights, which is incorporated herein by reference, and any amendments to these documents.

1.2 *Plan Purpose.* This Plan is intended, and shall be interpreted and administered, to comply with Section 125 of the Code and the regulations thereunder. The sole purpose of this Plan is to provide Qualified Benefits to Participants and it is maintained for their exclusive benefit.

2. DEFINITIONS

2.1 “*Account*” means an Adoption Assistance Flexible Spending Account, Dental Insurance Account, Dependent Care Flexible Spending Account, Disability Insurance Account, Health Insurance Account, Health Savings Account, Life Insurance Account, Medical Flexible Spending Account or Vision Insurance Account, established for a Participant.

2.2 “*Adoption Assistance Flexible Spending Account*” means an Account established for a Participant under the Plan for reimbursement of the Participant’s Adoption Expenses as provided in Section 137 of the Code.

2.3 “*Adoption Expense*” means an adoption-related expense under the standards established in Section 23(d) of the Code.

2.4 “*Code*” means the Internal Revenue Code of 1986, as amended, and corresponding provisions of future laws as amended.

2.5 “*Committee*” means the committee of persons that may be appointed by the Employer to serve as the Plan Administrator in accordance with Section 6.

2.6 “*Dental Insurance*” means any written policy or program of group dental insurance coverage maintained by the Employer, whether provided through a self-insured or a fully-insured policy with a third-party carrier.

2.7 “*Dental Insurance Account*” means an Account established for a Participant under the Plan for payment of Dental Insurance premiums.

2.8 “*Dependent*” means a dependent as defined in Section 152 of the Code, except (i) for purposes of Dental, Health and Vision Insurance and reimbursements from a Medical Flexible Spending Account, (a) a dependent is defined as in Section 105(b) of the Code, and (b) any child to whom Section 152(e) of the Code applies is treated as a dependent of both parents, and (ii) for purposes of Dependent Care Expenses, it means a Qualifying Individual.

2.9 “*Dependent Care Expense*” means an employment-related expense necessary for gainful employment of the Participant under the standards established in Section 21(b) of the Code.

2.10 “*Dependent Care Flexible Spending Account*” means an Account established for a Participant under the Plan for reimbursement of the Participant’s Dependent Care Expenses.

2.11 “*Disability Insurance*” means any written policy or program of group disability insurance coverage maintained by the Employer, whether provided through a self-insured or a fully-insured policy with a third-party carrier.

2.12 “*Disability Insurance Account*” means an Account established for a Participant under the Plan for payment of Disability Insurance premiums.

- 2.13 “Effective Date” means the day the Plan begins as stated in the Plan Highlights.
- 2.14 “Employee” means any person who performs services for the Employer as a common law employee and receives compensation for those services other than a pension, retirement allowance, retainer, or fee under contract. Persons who act only as directors are not Employees. Persons providing services to the Employer through temporary agencies, leasing organizations, or independent contractor arrangements are not Employees eligible to participate in the Plan, even though they subsequently may be classified as employees of the Employer for employment tax, unemployment insurance, or other purposes by a government agency or a court.
- 2.15 “Employer” means the Employer as identified in the Plan Highlights. Employer also means any related or successor employer assuming the obligations created in this Plan, as identified in the Plan Highlights.
- 2.16 “ERISA” means the Employee Retirement Income Security Act of 1974, as amended, and corresponding provisions of future laws. Notwithstanding any other term or provision of the Plan Document, the Summary Plan Description, or the Plan Highlights, the provisions of ERISA shall apply only to the extent that the statute so requires.
- 2.17 “Health Insurance” means any written policy or program of group medical insurance coverage maintained by the Employer, whether provided through a self-insured or a fully-insured policy with a third-party carrier.
- 2.18 “Health Insurance Account” means an Account established for a Participant under the Plan for payment of Health Insurance premiums.
- 2.19 “Health Savings Account” or “HSA” means an Internal Revenue Code Section 223 Account under which a Participant is covered, which is used to pay medical expenses eligible under the HSA. Such Accounts are established and maintained outside of the Plan with an HSA trustee/custodian.
- 2.20 “High Deductible Health Coverage” means coverage under a group term health plan maintained under a separate plan, program, insurance policy or contract and which: (i) satisfies the requirements of Sections 105 and 106 of the Code; and (ii) qualifies as a high deductible health plan as described in Section 223 of the Code and regulations and guidance issued thereunder.
- 2.21 “Highly Compensated Employee” means any Employee whose income or ownership percentage exceeds the limits defined in Section 125(e) of the Code with respect to overall participation in this Plan, Section 105(h)(5) of the Code with respect to the Medical Flexible Spending Account, and Health Savings Account; Section 414(q) of the Code with respect to the Adoption Assistance Flexible Spending Account and the Dependent Care Flexible Spending Account.
- 2.22 “Insurance Benefits” means the benefits indicated in the Plan Highlights to which a Participant or that Participant’s beneficiaries may be entitled (may include Dental, Disability, Health, Life and/or Vision Insurance).
- 2.23 “Key Employee” means any Employee who: (i) is an officer or owner of the Employer; and (ii) has annual compensation and/or ownership of the Employer as set forth in Section 416(i)(1) of the Code.
- 2.24 “Life Insurance” means any written policy or program of group term life insurance coverage (including accidental death and dismemberment coverage) maintained by the Employer, whether provided through a self-insured or a fully-insured policy with a third-party carrier.
- 2.25 “Life Insurance Account” means an Account established for a Participant under the Plan for payment of Life Insurance premiums.

- 2.26 “Medical Expense” means an expense for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. Medical Expenses may include obstetrical expenses, expenses for therapy, hospital services, nursing services, medical, laboratory, surgical, dental and other diagnostic and healing services, x-rays, prescribed drugs and medicines, artificial teeth or limbs, ambulance hire, transportation primarily for and essential to medical care, and all other expenses that are considered to be for medical care as that term is defined in Sections 105(b) and 213(d) of the Code and Treasury Regulations and/or other Internal Revenue Service Guidelines issued thereunder. Insurance premiums are not eligible for reimbursement from a Medical Flexible Spending Account.
- 2.27 “Medical Flexible Spending Account” means an Account established for a Participant under the Plan for reimbursement of eligible Medical Expenses for services provided to the Participant, the Participant’s Spouse or the Participant’s Dependent.
- 2.28 “Medical FSA Rollover” means an amount not to exceed 20% of the maximum salary reduction amount under Code section 125(i) for that Plan Year that is treated as contributed to a Medical Flexible Spending Account (FSA) in the Plan Year, but is unused at the end of the Plan Year and is allowed to rollover into the next Plan Year.
- 2.29 “Minimum Annual Deductible Amount” means the minimum annual deductible amount applicable to a participant under a high deductible health plan, as determined under Section 223 of the Code and regulations and guidance issued thereunder.
- 2.30 “Participant” means an Employee who meets the requirements for participation specified in Section 3.
- 2.31 “Plan” means the Flexible Benefit Plan set forth in this document and the accompanying Plan Highlights, as amended from time to time.
- 2.32 “Plan Administrator” means the person, entity, or committee identified as such in the Plan Highlights and as described in Section 6.
- 2.33 “Plan Highlights” means the accompanying document, which the Employer completes adopting certain provisions and outlining Employer-specific customizations as part of the Plan.
- 2.34 “Plan Year” means the period beginning and ending on the dates specified as the Plan Year in the Plan Highlights, and every twelve consecutive month period thereafter.
- 2.35 “Qualified Benefit” means one or more of the following benefits permitted under Section 125 of the Code and offered through the Plan (as specified in the Plan Highlights): (i) payment of Dental Insurance premiums; (ii) payment of Disability Insurance premiums; (iii) payment of Health Insurance premiums; (iv) payment of Life Insurance premiums; (v) payment of Vision Insurance premiums; (vi) reimbursement of Adoption Expenses, but only to the extent not otherwise reimbursable; (vii) reimbursement of Dependent Care Expenses, but only to the extent not otherwise reimbursable; (viii) reimbursement of Medical Expenses, but only to the extent not otherwise reimbursable; and (ix) Health Savings Account contributions.
- 2.36 “Qualifying Individual” means a qualifying individual as defined for purposes of Section 21(b) of the Code.
- 2.37 “Qualified Reservist Distribution” means a distribution of the unused contributions to a Medical Flexible Spending Account under Section 125(h) of the Code to a reservist (as defined in 37 U.S.C. § 101) ordered or called to active duty as provided in Section 4.14. Qualified Reservist Distributions shall only be allowed if the Employer has elected to permit such distributions as specified in the Plan Highlights.

- 2.38 “Salary Conversion Amount” means the portion of a Participant's compensation that the Participant contributes to his or her Account(s) for the Plan Year and for purposes of Sections 4.6, 4.7 and 4.9.1, such amount also includes the Benefit Credit, if any, described in Section 4.1 that is credited to a Participant’s Account(s).
- 2.39 “Service Provider” means Benefit Resource, LLC. and its authorized agents.
- 2.40 “Spouse” for purposes of any Qualified Benefit listed in Section 2.35 means a Participant’s legal Spouse if recognized by State and Federal law.
- 2.41 “Statutory Leave” means an unpaid leave of absence under the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act.
- 2.42 “Vision Insurance” means any written policy or program of group vision insurance coverage maintained by the Employer, whether provided through a self-insured or a fully-insured policy with a third-party carrier.
- 2.43 “Vision Insurance Account” means an Account established for a Participant under the Plan for payment of Vision Insurance premiums.

3. PARTICIPATION

- 3.1 Eligibility Requirements. An Employee who meets the eligibility requirements specified in the Plan Highlights shall be eligible to participate in the Plan except for the following restrictions:
- S Corp: Shareholders who are Employees and own more than 2% of the stock cannot participate. An Employee who is the Spouse, child, parent or grandparent of a more than 2% owner cannot participate. An individual who is a more than 2% shareholder at any time during the course of a Subchapter S corporation’s taxable year is treated as a more than 2% shareholder for the entire year.
 - Partnership: Partners cannot participate. An Employee who is the Spouse, child or parent of a partner can participate, if eligible.
 - Sole Proprietorship: Sole proprietor cannot participate. An Employee who is the Spouse, child or parent of a sole proprietor can participate, if eligible.
- 3.2 Participation Date. An eligible Employee shall become a Participant in the Plan on the date specified in the Plan Highlights.
- 3.3 Duration of Participation. Except as otherwise provided in this Plan, an Employee shall continue as a Participant so long as he or she remains an Employee and/or has elected COBRA continuation coverage, and continues to meet the eligibility requirements of Section 3.1.

If the Plan Administrator reasonably believes that a Participant knowingly has submitted an expense which is not eligible, the Plan Administrator may immediately discontinue the Participant’s participation in the Plan and prohibit the Participant from again participating in the Plan. The Plan Administrator may request from the Participant any information reasonably necessary to assist in such determination. Failure of the Participant to provide such information shall be cause for the Plan Administrator to find that the Participant knowingly submitted an expense that is not eligible.

- 3.4 Reinstatement of Former Participant. Subject to Sections 5.3.13, 5.3.14 and 5.4, a Participant whose employment with the Employer terminates and then resumes shall become a Participant again if and when he or she meets the requirements of Sections 3.1 and 3.2.

- 3.5 FMLA and USERRA Leaves of Absence. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA), then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain the Participant's benefits on the same terms and conditions as if the Participant were still an active Employee. To the extent coverage is not required to be continued by the FMLA or USERRA, the Participant will be treated as having terminated participation, as described under Section 4.9, except to the extent coverage is permitted or required to continue under the terms of the Employer's leave of absence policies or constituent Insurance Benefit plans.
- 3.6 Non-FMLA and USERRA Leaves of Absence. If a Participant goes on a leave of absence that is not subject to the FMLA or USERRA, the Participant will be treated as having terminated participation, as described under Section 4.9, except to the extent coverage is permitted or required to continue under the terms of the Employer's leave of absence policies or constituent Insurance Benefit plans.

4. **BENEFITS**

- 4.1 Benefit Credit. A Participant may receive a Benefit Credit which shall be allocated to his or her Account(s), provided that the Benefit Credit is subject to such amounts, limits, terms and conditions as are specified by the Employer. Unless otherwise set forth by the Employer, Employees who become eligible to participate in the Plan on a date other than the first day of the Plan Year shall be eligible to receive the Benefit Credit as specified by the Employer for that Plan Year, if any, reduced proportionately for each full or partial month (or any other period of time relevant in calculating the Benefit Credit) of the Plan Year during which the Employee was not eligible to participate in the Plan. If a Participant does not use the full value of his or her Benefit Credit when enrolling in the Plan and electing to receive Qualified Benefits for a Plan Year, all or part of the Participant's unused Benefit Credit shall be paid to that Participant as compensation and subject to such terms and conditions as specified by the Employer.
- 4.2 Salary Conversion Option. Each Participant may elect to receive full payment of compensation in cash or to contribute a portion of compensation to his or her Account(s) for Qualified Benefits.
- 4.3 Maximum Salary Conversion Amount. The total amount of compensation that a Participant may contribute to his or her Account(s) through salary reduction in any one Plan Year shall not exceed the total of (i) the Participant's cost for Dental, Disability, Health, Life and Vision Insurance premiums for the Plan Year (salary reductions in the last month of the Plan Year may be used to pay accident and health insurance premiums for the first month of the following Plan Year); plus (ii) the maximum amount that may be contributed by the Participant to his or her Adoption Assistance Flexible Spending Account, Dependent Care Flexible Spending Account, Medical Flexible Spending Account and/or Health Savings Account (less the Participant's Benefit Credit, if any, described in Section 4.1 that is allocable to such Accounts).
- 4.4 Credits to Accounts. For each Participant, a separate Account shall be maintained for each elected benefit which may include one or more of the Qualified Benefits as indicated in the Plan Highlights. The Salary Conversion Amount designated by each Participant shall be credited through equal payroll deductions to his or her Account(s). The amount credited to each Account for each pay period shall be the portion of the Salary Conversion Amount designated for that Account divided by: (i) the number of pay periods in the Plan Year; or (ii) for an Employee who becomes a Participant during the Plan Year, the number of pay periods remaining in the Plan Year after that Employee becomes a Participant. If applicable, each pay period, a Participant's Account(s) will also be credited with a pro-rata portion of the Participant's Benefit Credit, described in Section 4.1, which is allocable to such Account(s).

4.5 Payment or Reimbursement. Reimbursement of eligible Adoption, Dependent Care and/or Medical Expenses will be made directly to Participants on the schedule specified in the Plan Highlights and shall reduce the amount credited to the Participant's Account(s). The Service Provider shall provide reimbursement forms so that Participants can request reimbursements from their Adoption, Dependent Care and/or Medical Flexible Spending Accounts and/or institute such other procedures for paying claims relating to those Accounts, that the Service Provider or Plan Administrator, in its sole discretion, deems appropriate. Requests for reimbursement shall be accompanied by a copy of the bill, explanation of benefits or other documentation from an independent third-party supporting the reimbursement and shall contain the Participant's signed statement that the Adoption, Dependent Care and/or Medical Expense is not eligible for reimbursement from any other source and has not been reimbursed from any other source, as well as such other information that the Service Provider or Plan Administrator deems appropriate.

4.5.1 Claims relating to a Participant's Medical Flexible Spending Account may be paid and processed using a prepaid card designed for such purpose ("Beniversal® Card"). The availability of the Participant's Medical Flexible Spending Account funds on the card is outlined in the Plan Highlights. The Service Provider or Plan Administrator, in its sole discretion, shall adopt procedures to ensure that amounts paid with the Beniversal Card qualify as eligible Medical Expenses under the Plan. Such procedures shall comply with the regulations under Section 125 of the Code and include:

- If the Beniversal Card is used to pay an expense that is electronically validated at the point-of-sale to be an eligible Medical Expense, no further action is required.
- If the Beniversal Card is used to pay an expense that is not electronically validated at the point-of-sale to be an eligible Medical Expense, the Participant must submit such itemized bills, receipts or other information requested by the Service Provider or Plan Administrator to verify that the amount was an eligible Medical Expense.
- If the Participant fails to provide information to satisfy the Service Provider or Plan Administrator that amounts paid via the Beniversal Card are eligible Medical Expenses, the Plan Administrator will take whatever action it deems appropriate to require the Participant to repay the amount that has not been verified, including: (i) requesting the Participant to reimburse the Plan the amount that has not been verified; (ii) suspending the Participant's access to Medical Expense funds; (iii) offsetting future medical reimbursement claims by the amount paid via the Beniversal Card that has not been verified; (iv) suspending the Participant's eligibility to participate in the Plan; and (v) deducting from the Participant's taxable wages the amount of the expense paid via the Beniversal Card that has not been verified.

The Service Provider or Plan Administrator, in its sole discretion, may adopt such other rules that it deems appropriate that will govern the use of a prepaid card product to pay eligible medical expenses (e.g., canceling the card upon the Participant's termination of employment, establishing transaction limits on the card, charging fees to use such cards, etc.). If the Service Provider or Plan Administrator's correction efforts prove unsuccessful, the Participant remains indebted to the Plan for the amount of the payment that has not been verified. In that event, and consistent with its business practices, the Employer may treat the amount that has not been verified as it would any other business indebtedness.

4.6 Maximum Reimbursement Amounts. In the case of reimbursement for Adoption Expenses, the Participant may receive up to the amount then credited to the Participant's Adoption Assistance Flexible Spending Account. In the case of reimbursement for Dependent Care Expenses, the Participant may receive up to the amount then credited to the Participant's Dependent Care Flexible Spending Account. In the case of reimbursement for Medical Expenses, the Participant may receive an amount equal to the Salary Conversion Amount designated for the Participant's

Medical Flexible Spending Account for the Plan Year less the amount of any prior reimbursement from that Medical Flexible Spending Account for Medical Expenses for services provided during the Plan Year plus any Medical FSA Rollover from the prior Plan Year (if allowed by the Plan).

4.7 Forfeitability of Benefits for Flexible Spending Accounts. No Participant shall be entitled to reimbursement for Adoption, Dependent Care and/or Medical FSA expenses provided in a prior Plan Year unless a claim for reimbursement is submitted within the timeframe specified in the Plan Highlights. Except as provided in Sections 4.7.1 and 4.7.2 below, if the Salary Conversion Amount for a Plan Year exceeds the Qualified Benefits for the Plan Year, the Plan Highlights indicates the disposition of the unused portion of the Participant's Salary Conversion Amount. With respect to any forfeitures, the Plan Administrator, in its sole and absolute discretion, may: (i) apply the forfeited amount to any reasonable administrative expenses of the Plan; (ii) distribute the forfeited amount to all Participants in the Plan on a uniform basis not related to the amount of their individual forfeitures; or (iii) where permitted by law, return the forfeited amount to the Employer.

4.7.1 Grace Period. If the Grace Period is adopted by the Employer in the Plan Highlights, Adoption, Dependent Care and/or Medical FSA expenses provided during the Grace Period for a Plan Year may be treated as provided during that Plan Year for purposes of this Section 4. To the extent the contributions made for that Plan Year for such Qualified Benefits have not already been used for, or are not required to pay, such Qualified Benefits actually provided during the Plan Year, the contributions shall be used to pay such Qualified Benefits provided during the Grace Period, in accordance with provisions of this Section 4, provided all requirements and conditions for such Qualified Benefit are satisfied.

- If the total contributions to a Participant's Account exceed such Qualified Benefits paid from that Account for the Plan Year, including such Qualified Benefits provided during the Grace Period for the Plan Year, the Participant shall forfeit the excess contributions.
- This Subsection 4.7.1 shall be interpreted and applied in a manner consistent with IRS Notice 2005-42 and Treasury Regulations or other guidance issued to reflect or supersede IRS Notice 2005-42.

4.7.2 Medical FSA Rollover. If the Employer elects to permit Medical FSA Rollovers for a Plan Year in the Plan Highlights, to the extent the contributions made to a Medical Flexible Spending Account are not used for a Plan Year, an amount not to exceed 20% of the maximum salary reduction amount under Code section 125(i) for that plan year of the unused contributions shall not be forfeited at the end of the Plan Year, but shall be carried over to the Participant's Medical Flexible Spending Account for the next Plan Year, subject to the following rules:

- If the total contributions to a Participant's Account plus the amount of any Medical FSA Rollover exceed Medical Expenses paid from the Account for the Plan Year, the Participant shall forfeit the excess contributions.
- The Employer may elect to adopt a Grace Period or a Medical FSA Rollover, but not both.
- This Subsection 4.7.2 shall be interpreted and applied in a manner consistent with IRS Notice 2013-71 and Treasury Regulations or other guidance issued to reflect or supersede IRS Notice 2013-71.

4.7.3 Experience Gains for Flexible Spending Accounts. Any amounts forfeited by Participants in accordance with this Section 4.7 may be, in the sole and absolute discretion of the Plan Administrator, used as follows:

- In the case of forfeitures from the Adoption Assistance Flexible Spending Account or Dependent Care Flexible Spending Account only, retained by the Employer;
- If not retained by the Employer, or in the case of any Account other than an Adoption Assistance Flexible Spending Account or Dependent Care Flexible Spending Account, may be used only in one or more of the following ways: (i) to reduce required salary reduction amounts for the immediately following Plan Year, on a reasonable and uniform basis, as described in Prop. Treas. Reg. Section 1.125-5(o)(2) (or successor regulations); (ii) returned to employees on a reasonable and uniform basis, as described in Prop. Treas. Reg. Section 1.125-5(o)(2) (or successor regulations); (iii) to defray expenses to administer the plan; or (iv) any other purpose permitted by Prop. Treas. Reg. Section 1.125-5(o) (or successor regulations).

4.8 Cessation of Contributions. A Participant who ceases to make the required contributions to an Account shall cease to be provided with that benefit on the date of the last contribution, and shall be prohibited from making a new benefit election for the remaining portion of the period of coverage unless the Participant experiences a qualifying election change event described in Section 5.3. However, if a Participant ceases contributions to his or her Adoption Assistance, Dependent Care or Medical Flexible Spending Account consistent with a change described in Section 5.3, that individual may continue to request reimbursement from that Account within the timeframe specified in the Plan Highlights. However, if contributions cease due to loss of eligibility, the rules in Section 4.9 will apply. Participants may make contributions to and claim benefits from a Health Savings Account outside of this Plan even if HSA Benefits contributions under this Plan cease, in accordance with the HSA governing documents and procedures determined by the HSA trustee/custodian.

4.9 Loss of Eligibility (including Termination of Employment). Subject to Sections 5.3.13 and 5.3.14, claims for reimbursement of Adoption Expenses, Dependent Care Expenses and Medical Expenses for services provided after the loss of eligibility are controlled by the rules stated below. Reimbursement requests for eligible expenses must be submitted within the timeframe specified in the Plan Highlights.

4.9.1 A Participant who loses eligibility during the Plan Year may be eligible to elect, pursuant to this Section and Section 4.11, to continue a Medical Expense contribution election in effect through the end of the Plan Year by continuing to make contributions to that Medical Flexible Spending Account. A Participant making this election may request reimbursement for eligible Medical Expenses for services provided within the timeframe specified in the Plan Highlights. The amount available for reimbursement of Medical Expenses shall equal the Salary Conversion Amount designated for the Participant's Medical Flexible Spending Account for the Plan Year less the amount of any prior reimbursement from that Medical Flexible Spending Account during the Plan Year. A Participant who does not make this election may request reimbursement only for those eligible Medical Expenses for services provided prior to the loss of eligibility. Such request for reimbursement must be submitted within the timeframe specified in the Plan Highlights and, at the end of this run-out period, the Participant shall forfeit any amount remaining in his or her Medical Flexible Spending Account.

4.9.2 A Participant who loses eligibility during the Plan Year may request reimbursement for any eligible Adoption Expenses or Dependent Care Expenses for services provided through the end of the Plan Year during which he or she was a Participant. As stated in Section 4.6 above, the amount available for reimbursement of Adoption Expenses or Dependent Care Expenses shall be limited to the amount then credited to the Adoption Assistance Flexible Spending Account or Dependent Care Flexible Spending Account.

4.9.3 A Participant who loses eligibility to make contributions to the HSA for reasons other than termination of employment will still have access to HSA funds, including use of the

Beniversal Card for HSA to pay for Medical Expenses.

4.9.4 A Participant who loses eligibility to make contributions to the HSA because of termination of employment will have their HSA transferred to the trustee/custodian for administration. The trustee/custodian will contact the Participant directly regarding the HSA.

- 4.10 Coordination of Medical Flexible Spending Account Benefits. Medical Flexible Spending Account benefits under this Plan are intended to pay for Medical Expenses not previously reimbursed or reimbursable elsewhere through insurance or otherwise. Accordingly, the Medical Flexible Spending Account shall not be considered to be a group health plan for coordination of benefits purposes, and Medical Flexible Spending Account benefits shall not be taken into account when determining benefits payable under any other plan. If only a portion of a Medical Expense has been reimbursed elsewhere (e.g. because the health insurance plan imposes co-payment or deductible limitations), then the remaining portion of such Medical Expenses can be reimbursed from a Participant's Medical Flexible Spending Account if it otherwise meets the requirements for reimbursement under this Plan. If a Participant receives benefits under the Plan and is subsequently reimbursed for the expenses from any other source at any time, the Participant shall remit those benefits to the Employer to the extent of the reimbursement. If an Employer sponsors both a Health Reimbursement Account Plan and a Medical Flexible Spending Account under this Plan, then reimbursements shall be made first from the Medical Flexible Spending Account, unless otherwise specified in the Plan Highlights or under the coordination of benefits provisions of the Employer's Health Reimbursement Account Plan.
- 4.11 COBRA Health Continuation Coverage. The Employer shall advise each Participant of any rights he or she may have to continued Dental, Health and/or Vision Insurance coverage and continued reimbursement from the Participant's Medical Flexible Spending Account pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). To the extent permitted by Section 125 of the Code and regulations thereunder, Employees may remain Plan Participants during the COBRA continuation period.
- 4.12 Insurance Benefits. Any Insurance Benefits payable to Participants are described in the respective plan documents and summary plan descriptions (SPDs), and in the case of fully-insured benefits, in the contracts or policies issued by the insurance companies.
- 4.12.1 The Plan provides only for payment of insurance premiums. The actual Insurance Benefits to which a Participant or the Participant's beneficiaries may be entitled are separately and exclusively governed by the applicable plan documents, SPDs, contracts or policies.
- 4.12.2 The Employer does not guarantee payment of Insurance Benefits, and eligibility under the Plan does not guarantee that Participants will satisfy any requirements for coverage under the terms of the respective Insurance Benefit plan.
- 4.12.3 Current insurance premium costs and/or the Employer's share thereof shall be provided to eligible Employees before the beginning of each Plan Year. If premium costs change during the Plan Year, a revised schedule of insurance premium costs shall be distributed.
- 4.13 Statement of Benefits. The Plan Administrator shall provide by January 31 of each year, in the form provided under the Code, a statement to all Participants showing the Participant's contributions to his or her Adoption Assistance Flexible Spending Account, Dependent Care Flexible Spending Account and Health Savings Account for the previous calendar year.
- 4.14 Qualified Reservist Distributions. Notwithstanding any other provision of the Plan to the contrary, if the Employer permits Qualified Reservist Distributions as indicated in the Plan Highlights, a Participant who meets each of the following requirements may elect to receive a distribution of certain funds from his or her Medical Flexible Spending Account for a Plan Year:

4.14.1 The Participant's contributions to his or her Medical Flexible Spending Account for the Plan Year as of the date of the request for a Qualified Reservist Distribution exceed the reimbursements received from the Medical Flexible Spending Account for the Plan Year as of that date.

4.14.2 The Participant is ordered or called to active military duty for a period of at least one hundred eighty (180) days or for an indefinite period by reason of being a member of the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.

4.14.3 The Participant has provided the Plan Administrator with a copy of the order or call to active duty. An order or call to active duty of less than one hundred eighty (180) days' duration must be supplemented by subsequent calls or orders to reach a total of one hundred eighty (180) or more days.

4.14.4 During the period beginning on the date of the order or call to active duty and ending on the last day of the Plan Year during which the order or call occurred, the Participant delivers a written election to the Plan Administrator in such form as the Plan Administrator may prescribe, requesting a Qualified Reservist Distribution.

4.14.5 The Plan Administrator will review all requests for Qualified Reservist Distributions on a uniform and consistent basis. Requests for Qualified Reservist Distributions that are approved by the Plan Administrator shall be paid within a reasonable time, not to exceed sixty (60) days after the date of the Participant's request.

4.14.6 The amount of any Qualified Reservist Distribution made under this provision shall be equal to the Participant's contributions to his or her Medical Flexible Spending Account for the Plan Year as of the date of the request for a Qualified Reservist Distribution, minus the reimbursements received from the Medical Flexible Spending Account for the Plan Year as of that date. Notwithstanding any other provision of the Plan to the contrary, this portion of the Participant's balance may be distributed without regard to whether Medical Expenses have been provided. Any portion of the distribution that is not a reimbursement for verified Medical Expenses will be included in the Participant's gross income and wages.

4.14.7 A Participant who has requested a Qualified Reservist Distribution shall forfeit the right to receive reimbursements for Medical Expenses provided during the Plan Year and on or after the date of the distribution request. However, such a Participant may claim reimbursement for Medical Expenses provided during the Plan Year (or other period of coverage, if applicable) and before the date of the distribution request, even if such claims are submitted after the date of the distribution, so long as the total dollar amount of such claims does not exceed the amount of the Participant's contribution election under the Medical Flexible Spending Account for the Plan Year, less the sum of the Qualified Reservist Distribution under this provision and the reimbursements received from the Medical Flexible Spending Account for the Plan Year.

4.15 Health Savings Account Benefits.

4.15.1 For the purposes of this Section, the following terms have the following meanings:

- "*HSA Benefits*" means contributions made to a Health Savings Account on tax-free salary reduction basis under this Plan.
- "*General Health FSA*" means a General Medical Flexible Spending Account under this Plan or under such an account under any other employer's plan.

- “*Limited FSA*” means a Limited Medical Flexible Spending Account under this Plan or such an account under any other employer’s plan (e.g., a limited-purpose or post-deductible flexible spending account under another employer’s plan where coverage is limited to only vision, dental and/or post-deductible medical expenses, as described in Revenue Ruling 2004-45).
- “*General HRA*” means a General Health Reimbursement Account pursuant to IRS Notice 2002-45 established outside this Plan for reimbursement of eligible medical expenses.
- “*Limited HRA*” means a Limited Health Reimbursement Account pursuant to IRS Notice 2002-45 established outside this Plan for reimbursement of eligible medical expenses, where coverage is limited to only vision, dental and/or post-deductible medical expenses, as described in Revenue Ruling 2004-45.
- “*Trustee/Custodian*” is the financial institution responsible for holding and managing the assets in the HSA. The trustee/custodian is chosen by the Service Provider,

4.15.2 Eligible Employees may elect HSA Benefits only if the Employee is covered by High Deductible Health Coverage, meets other criteria for participation in an HSA outlined in Section 223 of the Code, and is enrolled in the HSA described in the Plan Highlights.

4.15.3 To the extent allowed by the IRS, the Employer may contribute to a Participant’s HSA under the Plan.

4.15.4 As provided in Section 5.3.15, Participants may prospectively change or revoke salary reduction elections for HSA Benefits at any time, so long as the election is made by any applicable administrative processing deadline imposed by the Employer, Plan Administrator, or Service Provider.

4.15.5 If an Employee participates in a General Health FSA or General HRA, then the Participant cannot elect HSA Benefits at any time during the General Health FSA or General HRA coverage period, even if the General Health FSA or General HRA balance is reduced to \$0 prior to the end of the coverage period. These restrictions do not apply to a Limited FSA or Limited HRA. In addition, if an Employee is a beneficiary under a General Health FSA or General HRA, such as if the Employee’s Spouse participates in a General Health FSA or General HRA and the Employee’s medical expenses are eligible for reimbursement from the Spouse’s General Health FSA or General HRA, then the Employee cannot elect HSA Benefits at any time during the General Health FSA or General HRA coverage period, even if the General Health FSA or General HRA balance is reduced to \$0 prior to the end of the coverage period.

4.15.6 An Employee who is a Participant or beneficiary in a General Health FSA cannot elect HSA Benefits for any of the first three calendar months following the close of the General Health FSA plan year if the General Health FSA provides a grace period under Prop. Treas. Reg. Section 1.125-1(e) or successor regulations. However, the Participant can elect HSA Benefits immediately following the close of the General Health FSA Plan Year despite any grace period if the account balance in the General Health FSA was \$0 at the close of the General Health FSA Plan Year. An Employee who is a Participant or beneficiary in a General Health FSA cannot elect HSA Benefits for the next Plan Year if the General Health FSA provides a Medical FSA Rollover into the General Health FSA for the next Plan Year. However, the Participant can elect HSA Benefits immediately following the close of the General Health FSA Plan Year despite any Medical FSA Rollover if the Participant declines or waives the Medical FSA Rollover before the close of the General Health FSA Plan Year or has the Medical FSA Rollover carried into an HSA compatible health FSA instead of the General Health FSA.

4.15.7 An Employee who is a Participant or beneficiary in a General HRA may elect HSA Benefits under this Plan following the close of the General HRA Plan Year if the General HRA

balance is \$0 at the close of the General HRA Plan Year, and the Participant or other account holder (as applicable) waives participation in the General HRA for the following HRA Plan Year prior to the beginning of that Plan Year (assuming waiver is permitted by the applicable General HRA plan). Alternatively, even if the General HRA balance is greater than \$0 at the end of the General HRA Plan Year, a Participant may elect HSA Benefits under this Plan following the close of the Plan Year if the Participant or other account holder (as applicable) elects to suspend participation in the General HRA for the following Plan Year, prior to the beginning of that Plan Year (assuming suspension is permitted by the applicable HRA plan).

4.15.8 The annual contribution to a Participant's HSA cannot exceed the limits described in Section 223 of the Code and applicable Department of Treasury and/or IRS regulations and guidance. In no event shall the amount elected for HSA Benefits under this Plan exceed the statutory maximum amount for HSA contributions corresponding with the Participant's High Deductible Health Coverage option for the calendar year in which the contribution is made. An additional catch-up contribution may be made by Participants who are age 55 or older.

In addition, the HSA Benefits maximum annual contribution shall be:

- reduced by any matching (or other) contribution made by the Employer on the Participant's behalf (other than HSA Benefits) made under the Plan, if any; and
- prorated for the number of months in which the Participant is an eligible Employee for HSA Benefits purposes.

4.15.9 HSA Benefits under this Plan consist solely of the ability to make contributions to the HSA on a tax-free salary reduction basis and for the Employer to make contributions to a Participant's HSA, if any.

4.15.10 An HSA is designed to pay for any eligible Medical Expenses for the Participant, Participant's Spouse or Participant's Eligible Dependents. This includes expenses paid toward deductibles, co-insurance, dental, vision, and chiropractic services provided *after* the HSA has been established. An HSA is considered established on the first date that the Participant is eligible to contribute to the Account.

4.15.11 Withdrawals from the HSA are limited to the balance in the Account. Funds for eligible Medical Expenses can be accessed by using the Beniversal Card for HSA at qualified merchants. Participants can also access funds in the HSA by using the bill payment service to pay a provider directly or they can reimburse themselves for out-of-pocket expenses by transferring funds from the HSA to a personal checking or savings account. It is the responsibility of the Participant to maintain all receipts for tax reporting and potential audit purposes. Funds used for ineligible expenses are subject to any applicable taxes and penalties.

4.15.12 The HSA is an Account that is established and maintained by an HSA trustee/custodian chosen by the Service Provider outside this Plan to be used primarily for the payment of eligible Medical Expenses as set forth in Section 223(d)(2) of the Code. The Employer has no authority or control over the funds deposited in an HSA. Even though this Plan may allow tax-free salary reduction contributions to an HSA in the form of HSA Benefits, and the Employer may elect to contribute to a Participant's HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain the HSA. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and is not a part of this Plan.

The Service Provider will maintain records to keep track of the HSA contributions a Participant makes via tax-free salary reductions, but it will not create a separate fund or otherwise segregate assets for this purpose.

The tax treatment of the HSA (including contributions and withdrawals) is governed by Section 223 of the Code.

5. ELECTION PROCEDURES

- 5.1 Annual Elections. Prior to the beginning of each Plan Year, the Plan Administrator shall provide each Employee eligible to participate in the Plan that Plan Year with election procedures. Employees who become eligible to participate in the Plan during the Plan Year shall be provided with election procedures once they meet the eligibility requirements for participation. Each Employee shall elect the amount of compensation that will be reduced automatically on a tax-free basis and contributed to the Employee's Account(s) to pay premiums for Dental, Disability, Health, Life and/or Vision Insurance (as indicated in the Plan Highlights), unless the Participant elects to pay for the premiums on an after-tax basis. Each Participant will need to specify the Salary Conversion Amount for the Plan Year, and the portion of those amounts to be credited to the Participant's Adoption Assistance Flexible Spending Account, Dependent Care Flexible Spending Account, Medical Flexible Spending Account and/or Health Savings Account. Elections must be completed and submitted on or before the date specified by the Plan Administrator. A Participant's failure to submit an election by the specified date shall be deemed an election not to make any contributions to an Adoption, Dependent Care, or Medical Flexible Spending Accounts or a Health Savings Account for the Plan Year. If the waiting period for eligibility for a new hire is less than thirty (30) days after the date of hire, then Employer may allow the Employee to submit an election within thirty (30) days after the date of hire with elections retroactive to the date of hire. Employees who terminate employment and resumes employment are subject to Section 5.4.
- 5.2 Irrevocability of Elections. Once an election is made for a Plan Year and the Plan Year commences, the election shall be irrevocable for the entire Plan Year, except as provided in Section 5.3.
- 5.3 Permissible Changes of Elections. Participants may revoke their contribution elections and make new elections during a Plan Year in accordance with the provisions of this Section. Any change in elections made during a Plan Year must be appropriate and necessary as a result of the events that qualify for the change. The Participant must submit the election change request to the Employer within the timeframe required by the Employer. If no timeframe is specified by the Employer, then the timeframe shall be thirty (30) days, except where a different time period is required by this Plan, a constituent Insurance Benefit plan, or by Section 125 of the Code and regulations thereunder. Participants cannot reduce elections for their Adoption Assistance Flexible Spending Account, Dependent Care Flexible Spending Account, and/or Medical Flexible Spending Account to the point where contributions for the Plan Year are less than the amount already reimbursable for that Plan Year. Election changes shall be effective at the earliest date permitted by Section 125 of the Code and regulations thereunder, unless a later date is specified by the Employer and/or the constituent Insurance Benefit plan. This Section shall be interpreted in a manner consistent with Section 125 of the Code and other guidance issued thereunder.

5.3.1 Change in Status. If eligibility for coverage changes, a Participant's contributions may change on account of and in a manner consistent with: (i) a change in the employment status of the Participant, the Participant's Spouse or the Participant's Dependents resulting from termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, change in worksite, or other change that causes the Participant, the Participant's Spouse or the Participant's Dependents to become or cease to be eligible for coverage under this Plan or other employer plan providing Qualified Benefits; (ii) a change in the Participant's legal marital status, (including marriage, divorce, death of a Spouse, legal

separation, or annulment); (iii) a change in the place of residence of the Participant, the Participant's Spouse or the Participant's Dependents; (iv) a change in a Dependent's eligibility for coverage due to age, student status, marriage or similar circumstance, or, for a Dependent Care Flexible Spending Account, a change in the status of an individual as a Qualifying Individual; (v) a change in the number of Dependents (including a change resulting from a birth, death, adoption or placement for adoption of a child); or (vi) any other change considered to be a change in status under Section 125 of the Code and regulations thereunder.

5.3.2 *Change in Cost.* If the Participant's cost for Dental, Disability, Health, Life or Vision Insurance coverage changes, there shall be an automatic corresponding change to their Dental, Disability, Health, Life or Vision Insurance contributions; provided, however, if there is a significant increase in cost of a Dental, Disability, Health, Life or Vision Insurance coverage option, an affected Participant may revoke the election of that coverage and may elect another option providing similar coverage (if available) with a corresponding change to contributions, or drop coverage if no other benefit package option providing similar coverage is available.

If there is a change in a Participant's dependent care provider or in the dependent care provider's cost for services, the Participant may make a corresponding change to Dependent Care Account contributions; provided that in the case of a change in a dependent care provider's cost for services the dependent care provider is not a relative of the Participant within the meaning of Sections 152(a)(1) through (8) of the Code, incorporating rules of Sections 152(a)(1) and (2) of the Code.

5.3.3 *Significant Curtailment or Cessation of Coverage.* If there is a significant curtailment in or cessation of a Participant's Dental, Disability, Health, Life or Vision Insurance coverage (including elimination of that coverage option), or Dependent Care, and such curtailment or cessation constitutes reduced coverage for Participants generally, an affected Participant may: (i) revoke the election of that coverage and may elect another option providing similar coverage (if available) with a corresponding change to Dental, Disability, Health, Life or Vision Insurance or Dependent Care Account contributions; or (ii) drop coverage if no similar benefit option is available.

5.3.4 *Significant Improvement in or Addition of Coverage.* If a Dental, Dependent Care, Disability, Health, Life or Vision Insurance coverage option is added or significantly improved, the Dental, Disability, Health, Life or Vision Insurance or Dependent Care Account contributions of a Participant who elects the new or improved coverage option shall be changed to correspond to the cost of the coverage.

5.3.5 *Change in Coverage under other Employer's Plan.* A Participant may change contributions (other than Medical Flexible Spending Account contributions) under this Plan in a manner consistent with a change by the Participant's Spouse, former Spouse or Dependent under another Qualified Benefits plan if the change under such other plan: (i) is permitted under other events listed in Sections 5.3; or (ii) is made for the normal election period under such other plan and that period is different from the Plan Year of this Plan.

5.3.6 *Loss of coverage under Governmental or Educational Group Health Plan.* A Participant may change contributions to add similar coverage under this Plan for the Participant, the Participant's Spouse or the Participant's Dependents if that individual loses Dental, Health or Vision coverage under any group coverage sponsored by a governmental or educational institution.

5.3.7 *Purchase of Coverage Through a Marketplace (Exchange).* A Participant may revoke contributions to the Health Insurance Account under this Plan when the Participant is eligible for a special enrollment period to enroll in a qualified health plan through a Marketplace, as established by the Affordable Care Act (ACA); or the Participant seeks to enroll in a qualified

health plan through a Marketplace during the Marketplace's annual enrollment period. The revocation of the Health Insurance Account contributions corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, into a qualified health plan through a Marketplace. The new coverage must be effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

5.3.8 *Health Plan Special Enrollment Rights*. A Participant's Health Insurance Account contributions may be changed in a manner and within a timeframe consistent with the exercise of special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This special rule also applies to a Participant's Dental and Vision Insurance Account contributions and Medical Flexible Spending Account contributions to the extent the Participant's Dental and Vision Insurance Benefits and Medical Flexible Spending Account are subject to special enrollment rights under HIPAA.

5.3.9 *COBRA Coverage*. If a Participant, the Participant's Spouse or the Participant's Dependents become eligible for continuation coverage under the Consolidated Omnibus Reconciliation Act of 1985 (or similar State law), the Participant may increase the Dental, Health and Vision Insurance Account contributions to pay for the coverage.

5.3.10 *Court Judgment, Decree or Order*. A Participant's Dental, Health or Vision Insurance Account contributions may be increased to pay for a Dependent child's or foster child's Dental, Health or Vision Insurance as required under a court judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody including a Qualified Medical Child Support Order (QMCSO) as defined under Section 609 of ERISA. Similarly, such contributions may be reduced to reflect any decrease in the Dental, Health or Vision Insurance cost if such judgment, decree or order requires someone else to provide health coverage for such child. To the extent permitted under Section 125 of the Code, a Participant's Medical Flexible Spending Account contributions may also be increased or reduced in a manner consistent with such court judgment, decree or order.

5.3.11 *Entitlement to Medicare or Medicaid*. A Participant's Health Insurance Account contributions may be reduced if the Participant, the Participant's Spouse or the Participant's Dependents become entitled to Medicare or Medicaid coverage (other than only the program for distribution of pediatric vaccines), and may be increased if the Participant, the Participant's Spouse or the Participant's Dependents lose such Medicare or Medicaid eligibility. To the extent permitted under Section 125 of the Code, a Participant's Dental and Vision Insurance contributions and Medical Flexible Spending Account contributions may also be reduced or increased when the Participant, the Participant's Spouse or the Participant's Dependents become entitled to, or lose, such Medicare or Medicaid eligibility.

5.3.12 *Reduction in Hours of Service*. Participants may revoke contribution elections under this Plan to the Health Insurance Account whose hours of service was reduced to average less than thirty (30) hours of service per week so long as the reduction does not affect the eligibility for coverage under the Employer maintained Health Insurance. The revocation of the contributions to the Health Insurance Account corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another health plan that provides minimum essential coverage as required by the Affordable Care Act (ACA). The new coverage must be effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

5.3.13 *Special Rule for Statutory Leave*. If a Participant takes a Statutory Leave, the Participant may: (i) revoke the elections at the beginning of the Statutory Leave and make new elections at the end of the Statutory Leave; or (ii) keep the elections in place by prepaying contributions through tax-free payroll deductions before the beginning of the Statutory Leave or continuing to pay contributions through after-tax contributions during the Statutory Leave; provided, however,

if the Statutory Leave spans two Plan Years, the Participant may not prepay contributions due after the last day of the Plan Year in which the Statutory Leave begins. A Participant shall not be eligible for reimbursement from the Dependent Care or Medical Flexible Spending Account during a period in which contributions cease as a result of a Statutory Leave. Notwithstanding the above, the Employer may elect to pay a Participant's contributions during a Statutory Leave and recover the Participant's share of the cost of these payments through tax-free payroll deductions after the Statutory Leave if the Employer does so for all Participants in the case of a Statutory Leave or non-statutory unpaid leave.

5.3.14 Special Rule for Adoption Assistance. Participants may prospectively change or revoke salary reduction elections for an Adoption Assistance Flexible Spending Account in the event of the commencement or termination of an adoption proceeding. This is the only qualifying event that would permit an election change with respect to an Adoption Assistance Flexible Spending Account.

5.3.15 Prospective Changes to Health Savings Account Contributions Allowed at any Time. Participants may prospectively change or revoke salary reduction elections for Health Savings Account contributions at any time, so long as the election is made by any applicable administrative processing deadline imposed by the Employer, Service Provider or Plan Administrator.

5.4 Termination of Employment. Notwithstanding Section 5.3.1, but subject to Sections 5.3.13 and 5.3.14, if a Participant's employment with the Employer terminates and then resumes in the same Plan Year within a period of thirty (30) days or less, that individual's elections in effect before termination shall automatically be reinstated upon resumption of employment, unless some other intervening event has occurred that would permit a change in election(s). This does not apply to Health Savings Accounts as subject to Section 5.3.15.

5.5 Nondiscrimination Requirements. The Plan Administrator may in its sole and absolute discretion take any actions that it deems appropriate to assure compliance with all applicable nondiscrimination requirements and all applicable limitations on Qualified Benefits provided to Key Employees or Highly Compensated Employees. These actions may include without limitation the modification of elections by Key Employees and Highly Compensated Employees with or without their consent. If at any time during the Plan Year the Plan Administrator determines that Dependent Care Flexible Spending Account contributions by Highly Compensated Employees will cause the Plan to fail the average benefits test of Section 129(d)(8) of the Code, the Plan Administrator shall take such actions it deems appropriate, which may include, without limitation, reducing pro rata or terminating such contributions, as necessary, to satisfy the test.

6. PLAN ADMINISTRATION

6.1 Plan Administrator. The Employer may appoint a person or committee of persons to act as Plan Administrator and may remove the Plan Administrator from office at any time. Any such appointment or removal shall be in writing. If no appointment is made, the Employer shall be the Plan Administrator.

6.2 Powers. The Plan Administrator has full discretionary authority and responsibility to control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right to interpret the Plan (but not to modify or amend the Plan) and to decide any and all questions arising in the administration, interpretation, and application of the Plan. The Plan Administrator shall establish whatever rules it finds necessary for the operation and administration of the Plan and shall endeavor to apply such rules in its decisions so as not to discriminate in favor of any person. The decisions of The Plan Administrator or its action with respect to the Plan shall be conclusive and binding upon the Employer and all persons having or

claiming to have any right or interest in or under the Plan, except to the extent the Plan Administrator's decision is subject to review by a court of law.

- 6.3 The Committee. If the Employer designates a committee of persons (the "Committee") to serve as the Plan Administrator, the members of the Committee may elect from their number a chairman, who needs not be an Employee, and may appoint a secretary, who needs not be an Employee or a member of the Committee. They may appoint from their number such subcommittees with such powers as they shall determine. They may allocate responsibility among themselves or delegate any of their duties or responsibilities to other persons in accordance with this Section 6. A member of the Committee may resign at any time by delivering a written resignation to the Employer.

The Committee may hold meetings upon such notice, at such place or places, and at such time or times as they may determine. A majority of the members of the Committee shall constitute a quorum for the transaction of business. All resolutions or other actions taken by the Committee shall be by vote of a majority of those present at a meeting of the Committee at which a quorum shall be present or, if they act without a meeting, in writing by all the members of the Committee.

- 6.4 Delegation of Responsibilities. The Plan Administrator may delegate any of its duties or responsibilities to other persons, including the Employer or any of its officers or Employees. Any such allocation or delegation of responsibilities shall be by an instrument in writing, setting forth specifically the delegated duties, signed by or on behalf of the Plan Administrator and the delegated person and shall be exercised in a reasonable manner taking into account the discretionary or ministerial nature of the responsibility allocated or delegated and the capabilities of such person or persons to whom the responsibility is allocated or delegated.

- 6.5 Third-Party Contracts. The Plan Administrator or any person or persons to whom the Plan Administrator has delegated responsibilities may employ, with the approval of the Plan Administrator, one or more accountants, actuaries, legal counsel or other persons as shall be deemed necessary for the effective control and management of the operation and administration of the Plan. The Plan Administrator, the Employer and its officers and directors, and any person to whom any duty or responsibility has been delegated by the Plan Administrator shall be entitled to rely upon all tables, valuations, certificates, opinions and reports furnished by any duly appointed accountant, actuary, legal counsel or other person and shall be fully protected in respect of any action taken or permitted by them in good faith in reliance upon any such tables, valuations, certificates, reports or opinions.

- 6.6 Expenses. The Plan Administrator shall not receive any compensation from the Plan for its services, but the Employer may pay the Plan Administrator a salary and the Plan may reimburse the Plan Administrator for any necessary expenses incurred.

- 6.7 Records. The Plan Administrator shall maintain records showing the fiscal transactions of the Plan.

- 6.8 Indemnification. To the extent not covered by insurance and to the fullest extent permitted by law and the Employer's governing rules, each person who is or has been the Plan Administrator, including each person who is or has been a member of the Committee, if applicable, or any officer or Employee of the Employer who has been delegated responsibilities by the Plan Administrator, shall be indemnified by the Employer against expenses (including amounts paid in settlement with the approval of the Employer) reasonably incurred by him or her in connection with any action, suit, or proceeding to which he or she may be a party or with which he or she shall be threatened by reason of being or having been or acted on behalf of the Plan Administrator, except in relation to matters as to which he or she shall be adjudged in such action, suit, or proceeding to be liable for a breach of any fiduciary responsibility under ERISA. The

foregoing right of indemnification shall be in addition to any other rights to which the Plan Administrator may be entitled as a matter of law.

7. CLAIMS AND APPEALS PROCEDURE

- 7.1 Claims and Appeals Procedure Overview. Participants or beneficiaries who disagree with a decision concerning their right to participate in the Plan or to receive reimbursement of Adoption Assistance Expenses, Dependent Care Expenses and/or Medical Expenses may file a claim in writing with the Plan Administrator. Claims and/or appeals of denied claims may be made by the Participant or the Participant's authorized representative (the "Claimant").

Claims and appeals relating solely to eligibility to participate in the Plan (including eligibility to make or change elections for a particular Qualified Benefit available under the Plan) are subject only to the Eligibility Claims and Appeal Procedure contained in Section 7.2 below. Claims and appeals relating in whole or in part to benefits claimed under the terms of the Plan are subject to the Claims and Appeals Procedures outlined in Sections 7.3 and 7.4 below.

7.1.1 Compliance with the Patient Protection and Affordable Care Act (PPACA). The plans governed by these claims procedures are excepted benefits that are not subject to the claims procedure requirements under the Patient Protection and Affordable Care Act (PPACA).

- 7.2 Eligibility Claims and Appeals Procedure. The following procedures apply if a Claimant is inquiring about eligibility to participate in the Plan (including eligibility to make or change elections for a particular Qualified Benefit available under the Plan). These rules do not apply if a Claimant is claiming the right to receive benefits under the Plan, rather than just inquiring about eligibility to participate.

Claimants who disagree with a decision concerning their right to participate or make or change elections in the Plan may file a claim in writing with the Plan Administrator. The Plan Administrator will review the claim and generally will notify the Claimant of its decision within ninety (90) days after it receives the claim. However, if the Plan Administrator determines that special circumstances require an extension of time to decide the claim, it may obtain an additional ninety (90) days to decide the claim. Before obtaining this extension, the Plan Administrator will notify the Claimant, in writing and before the end of the initial 90-day period, of the special circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision.

If an eligibility claim is denied in whole or in part, the Plan Administrator shall provide a written notice within the time period described above, setting forth: (i) the specific reasons for the denial; (ii) specific reference to the provision of this Plan upon which the denial is based; (iii) any additional material or information the Claimant should furnish to perfect the claim and an explanation of why such material or information is necessary; (iv) the Claimant's right to receive, upon request and free of charge, reasonable access to and copies of all documents and information relevant to the claim; and (v) a description of the Plan's internal review procedures, information regarding how to file an appeal, and the time limits applicable to such procedures, including the Claimant's right to file a civil action following an adverse benefit determination on review. The notice will be written in a manner calculated to be understood by the claimant.

Claimants who disagree with the decision reached by the Plan Administrator may submit a written appeal within sixty (60) days of receiving the initial adverse decision. The written appeal should clearly state the reason or reasons why the Claimant disagrees with the Plan Administrator's decision. The Claimant may submit written comments, documents, records and other information relating to the claim even if such information was not submitted in connection with the initial claim for benefits. Additionally, upon request and free of charge, the Claimant

may have reasonable access to and copies of all Plan documents, records and other information relevant to the claim.

The Plan Administrator will review the appeal and will generally issue a written decision within sixty (60) days of its receipt. If special circumstances require an extension of time for reviewing the claim, the Claimant will be notified in writing. The notice will be provided prior to the commencement of the extension, describe the special circumstances requiring the extension and set forth the date the Plan Administrator will decide the appeal, which date will be no later than sixty (60) days from the end of the first 60-day period.

Once the Plan Administrator has made a decision, the Claimant will receive written notification of the decision. In the case of an adverse decision, the notice will: (i) explain the reason or reasons for the decision; (ii) include specific references to Plan provisions upon which the decision is based; and (iii) indicate that the Claimant is entitled to, upon request and free of charge, reasonable access to and copies of documents, records, and other information relevant to the claim. The notice will also include a statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, a statement describing voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and a statement of the Claimant's right to bring an action under ERISA.

7.3 Benefits Claims Procedure. Claims for benefits under any policy of Dental Insurance, Disability Insurance, Health Insurance, Life Insurance, or Vision Insurance purchased with premiums paid under this Plan, or for benefits from a Health Savings Account, shall be made according to the procedures established in the written policy or program established by the respective third-party carrier or trustee/custodian.

Claims for Adoption Assistance Expense, Dependent Care Expense and/or Medical FSA expense Qualified Benefits shall be paid in accordance with the terms of the Plan. Claims for Adoption Assistance Expense, Dependent Care Expense and/or Medical FSA expense Qualified Benefits shall be made to the Service Provider on a form provided by the Service Provider, provided that if a Beniversal Card is used to pay an expense that is electronically validated at the point-of-sale to be an eligible expense, in accordance with the rules and procedures set forth in Section 4.5. Each claim form must be accompanied by such documentation or certifications as may be required in accordance with Section 4.5 and must be received by the Service Provider within the timeframe indicated in the Plan Highlights.

The Service Provider or Plan Administrator, in its sole and complete discretion, will decide if a claim should be reimbursed. If any part of a claim for Medical Expenses under Medical FSA is denied, absent any necessary extension, the Service Provider shall provide a written notice as soon as possible, but in no event more than thirty (30) days after the receipt of the claim by the Service Provider, setting forth: (i) the specific reasons for the denial; (ii) sufficient information to identify the claim involved, including the date of service, the health care provider, and if applicable, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; (iii) specific reference to the provision of this Plan upon which the denial is based; (iv) any additional material or information the Claimant should furnish to perfect the claim and an explanation of why such material or information is necessary; (v) the Claimant's right to receive, upon request and free of charge, reasonable access to and copies of all documents and information relevant to the claim; (vi) a description of the Plan's review procedures, information regarding how to file an appeal, and the time limits applicable to such procedures, including the Claimant's right to file a civil action following an adverse benefit determination on review; (vii) 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 will be provided free of

charge to the Claimant upon request; (viii) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice shall also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the member's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (ix) the identity of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination. The notice will be written in a manner calculated to be understood by the Claimant.

If special circumstances beyond the control of the Plan require it, the Service Provider may extend the time for deciding a Medical FSA Medical Expense claim for up to an additional fifteen (15) days by providing written notice of such extension to the Claimant. If the extra time is needed because the Claimant has not provided information needed to decide the claim, the notice will also describe the needed information and the Claimant will have forty-five (45) days to provide the needed information. If the Claimant provides additional information in response to such a request, a decision will be rendered within fifteen (15) days of when the information is received.

If any part of a claim for Adoption Expenses or Dependent Care Expenses is denied, absent special circumstances requiring an extension of time, the Service Provider shall provide a written notice, within ninety (90) days after the receipt of the claim by the Service Provider, setting forth the aforementioned items (i) through (vii) unless extra time is needed to decide the claim. If extra time is needed, the ninety (90) day period may be extended by an additional ninety (90) days (for a total of one-hundred eighty (180) days), and the Claimant will be notified in writing during the initial ninety (90) day period of the special circumstances requiring an extension and the date by which the Service Provider expects to render a decision.

7.4 *Benefits Claims Review Procedure.* Review of any adverse benefit determination under any policy of Dental Insurance, Disability Insurance, Health Insurance, Life Insurance, or Vision Insurance purchased with premiums paid under this Plan, shall be made according to the procedures established in the written policy or program established by the respective third-party carrier. Claimants who disagree with a decision concerning their right to participate in the Plan or to receive Qualified Benefits may file an appeal in writing with the Plan Administrator.

If a claim for Medical Expenses under a Medical FSA is denied and a review is desired, the Claimant shall have one-hundred eighty (180) days after receipt of written notice of denial in which to notify the Plan Administrator in writing. If a claim for Adoption Expenses or Dependent Care Expenses is denied and a review is desired, the Claimant shall have sixty (60) days after receipt of written notice of denial in which to notify the Plan Administrator in writing.

In requesting a review, the Claimant may review this Plan or any documents relating to it and submit any written comments, documents, records and other information the Claimant may feel appropriate, without regard to whether such information was submitted or considered in the initial benefit determination made by the Service Provider. The Claimant may obtain, free of charge and upon request, records and other information relevant to the claim, without regard to whether such information was relied upon by the Service Provider in making the initial benefit determination.

The Plan Administrator shall review an appeal for Medical FSA Medical Expenses and provide a written decision within sixty (60) days. The review shall not afford deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual. If a Claimant's Medical FSA Medical Expense appeal is denied and the denial was based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional with training and experience in the relevant medical field. This health care professional will not have been involved in the original denial decision, nor be

supervised by the health care professional involved in the initial decision. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination will be identified in the written appeal response, without regard to whether the advice was relied upon in making the benefit determination.

The Plan Administrator shall review an appeal for Adoption Expenses or Dependent Care Expenses and provide a written decision within sixty (60) days, unless extra time is needed to review the claim. If extra time is needed, the sixty (60) day period may be extended by an additional sixty (60) days (for a total of one-hundred twenty (120) days) and the Claimant shall be notified in writing within the initial sixty (60) day period of the special circumstances requiring an extension and the date by which the Plan Administrator expects to render a decision. If extra time is needed because the Claimant has not provided information needed to review the claim, and if the Claimant provides additional information in response to such a request, a decision will be rendered within sixty (60) days of when the information is received.

If during the pendency of the claim or appeal the Plan obtains any new or additional evidence that is considered, relied upon, or generated by or at the direction of the Plan in connection with the claim, the Plan will provide the Claimant with the new or additional evidence at no cost as soon as possible and sufficiently in advance of the date when the Plan must provide notice of its decision regarding the claim on appeal to give the Claimant a reasonable opportunity to respond prior to that date.

Additionally, before the Plan denies such a claim on appeal in whole or part based on a new or additional rationale, the Plan will provide the Claimant with the new or additional rationale at no cost as soon as possible and sufficiently in advance of the date when the Plan Administrator must provide notice of its decision regarding the claim on appeal to give the Claimant a reasonable opportunity to respond prior to that date.

The Plan Administrator's written decision shall set forth the same elements required for the written notice of claim denial in Section 7.3 above. In addition, the written decision on appeal will also include a statement describing voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, a statement of the member's rights to bring a civil action under section 502(a) of ERISA.

8. AMENDMENT AND TERMINATION OF THE PLAN

8.1 Amendment. The Employer may amend the Plan at any time or from time to time by an instrument in writing executed with the same formality as this instrument. Any amendment shall be effective only for periods after the later of its adoption date or effective date. However, no amendment shall affect the rights of Participants with respect to the payment of Qualified Benefits incurred prior to the effective date of the amendment.

8.2 Termination. The Plan is intended by the Employer to be an indefinite program for the provision of Qualified Benefits for its Employees. The Employer nevertheless reserves the right to terminate the Plan at any time and for any reason. Such termination shall be effected by a written instrument executed by the Employer with the same formality as this instrument. Termination of the Plan shall not affect the rights of Participants with respect to the payment of Qualified Benefits incurred prior to the effective date of termination.

9. MISCELLANEOUS

9.1 No Employment Rights Conferred. The adoption and maintenance of the Plan shall not be deemed to constitute a contract between the Employer and any Participant or to be a consideration for, or an inducement to or condition of, the employment of any person.

Nothing herein contained shall be deemed to: (i) give to any Participant the right to be retained in the employment of the Employer; (ii) interfere with the right of the Employer to discharge any Participant at any time; (iii) give to the Employer the right to require any Participant to remain in its employment; or (iv) interfere with any Participant's right to terminate employment with the Employer at any time.

- 9.2 No Compensation for Other Purposes. Qualified Benefits paid under the terms of this Plan shall not be treated as additional compensation to the Participant for purposes of determining contributions or benefits under any qualified retirement plan maintained by the Employer or for purposes of any other benefit obligations of the Employer unless otherwise provided under the terms of the retirement plan or other benefit program.
- 9.3 General Assets. Payment of Qualified Benefits shall be made out of the assets of the Employer generally available for payment of its obligations. There shall be no special trust fund for payment of Qualified Benefits. Except as provided in a qualified medical child support order (within the meaning of Section 609(a) of ERISA), and except to the extent that this provision may be contrary to other law, Qualified Benefits payable from the Plan shall not be subject to assignment or transfer or otherwise alienable, either by voluntary or involuntary act of a Participant or by operation of law, nor subject to attachment, execution, garnishment, or other seizure under any legal or equitable process.
- 9.4 Impossibility of Performance. In the event that it becomes impossible for the Employer to perform any act under the Plan, that act shall be performed which in the judgment of the Employer shall most nearly carry out the intent and purposes of the Plan.
- 9.5 Governing Law. All legal questions pertaining to the Plan shall be determined in accordance with the laws of the Plan Administrator's State except when those laws are preempted by the laws of the United States.
- 9.6 Code and Legal Requirements. The Plan is intended and shall be interpreted to comply with all applicable laws and regulations, including all applicable Code requirements. Such requirements are incorporated by reference to the extent required and not expressly set forth herein and to the extent any provision of the Plan conflicts with applicable legal requirements, shall be reformed to effect compliance.
- 9.7 Special Relief Provisions that Employers Can Elect under IRS Notice 2020-29. IRS Notice 2020-29 permits Employers to elect certain temporary relief provisions. Specifically, to the extent elected by the Employer, the following rules apply and shall supersede any Plan provision to the contrary:
- During the 2020 calendar year and subject to such limitations that are specified by the Employer, a Participant may on a prospective basis revoke an election, make a new election, or decrease or increase an existing election regarding the Participant's Medical Flexible Spending Account. Any change allowed shall not permit a revocation or decrease in election below the amount already reimbursed.
 - During the 2020 calendar year and subject to such limitations that are specified by the Employer, a Participant may on a prospective basis revoke an election, make a new election, or decrease or increase an existing election regarding the Participant's Dependent Care Flexible Spending Account.
 - During the 2020 calendar year and subject to such limitations that are specified by the Employer, a Participant may on a prospective basis (i) make a new election for Employer-sponsored Health Insurance, Dental Insurance, and/or Vision Insurance if the Participant initially declined to elect such employer-sponsored coverage; (ii) revoke an existing

election for Employer-sponsored Health Insurance, Dental Insurance, and/or Vision Insurance and make a new election to enroll in different Employer-sponsored Health Insurance, Dental Insurance, and/or Vision Insurance (including changing enrollment from self-only coverage to family coverage); or (iii) revoke an existing election for Employer-sponsored Health Insurance, Dental Insurance, and/or Vision Insurance, provided that the Participant attests in writing that the Participant is enrolled, or immediately will enroll, in other health coverage not sponsored by the Employer.

- Subject to such limitations that are specified by the Employer, a Participant may apply unused amounts remaining in the Participant's Medical Flexible Spending Account or Dependent Care Flexible Spending Account as of the end of a grace period ending in 2020 or the Plan Year ending in 2020 to pay or reimburse expenses incurred for the same qualified benefit through December 31, 2020.

The above provisions are qualified by, and subject to, the requirements of IRS Notice 2020-29.

9.8 *Special Claims Rules Adopted in Connection with COVID-19.* The Internal Revenue Service and Employee Benefits Security Administration issued a joint rule in May 2020 extending the timeframes under ERISA and the Internal Revenue Code for making certain benefits-related elections, as further amended and clarified by EBSA Disaster Relief Notice 2021-01 and other guidance (collectively, the "Joint Notice"). To the extent required by the Joint Rule, certain periods beginning from March 1, 2020 until 60 days after the end of the National Emergency Concerning the Novel Coronavirus Disease (subject to a 12-month maximum period), will be disregarded in determining the following periods and dates:

- The 30-day period (or 60-day period, if applicable) to request special enrollment under ERISA section 701(f) and Code section 9801(f);
- The 60-day election period for COBRA continuation coverage under ERISA section 605 and Code section 4980B(f)(5);
- The date for making COBRA premium payments pursuant to ERISA section 602(2)(C) and (3) and Code section 4980B(f)(2)(B)(iii) and (C);
- The date for Participants to notify the Plan of a qualifying event or determination of disability under ERISA section 606(a)(3) and Code section 4980B(f)(6)(C);
- The date within which Participants may file a benefit claim under the Plan's claims procedures; and
- The date within which claimants may file an appeal of an adverse benefit determination under the Plan's claims procedure.

The above rules only apply to the portions of the Plan that are subject to ERISA (e.g., the special rules do not apply to Dependent Care Flexible Spending Accounts).

9.9 *Special Relief Provisions that Employers Can Elect under the Consolidated Appropriations Act, 2021.* Under the Consolidated Appropriations Act, 2021 (the "CAA"), Employers may elect certain temporary relief provisions. Specifically, to the extent elected by the Employer, the following rules apply and shall supersede any Plan provision to the contrary:

- Subject to such limitations that are specified by the Employer, for Plan Years ending in 2020, Participants may be permitted to carry over (under rules similar to the rules applicable to the Medical Flexible Spending Account) any unused benefits or contributions remaining in the Participant's Medical Flexible Spending Account or

Dependent Care Flexible Spending Account from such Plan Year to the Plan Year ending in 2021.

- Subject to such limitations that are specified by the Employer, for Plan Years ending in 2021, Participants may be permitted to carry over (under rules similar to the rules applicable to the Medical Flexible Spending Account) any unused benefits or contributions remaining in the Participant's Medical Flexible Spending Account or Dependent Care Flexible Spending Account from such Plan Year to the Plan Year ending in 2022.
- Subject to such limitations that are specified by the Employer, the Employer may extend the grace period for a Plan Year ending in 2020 or 2021 to 12 months after the end of such Plan Year with respect to unused benefits or contributions remaining in a Participant's Medical Flexible Spending Account or Dependent Care Flexible Spending Account.
- Subject to such limitations that are specified by the Employer, the Employer may permit an employee who ceases to participate in the Plan during calendar years 2020 or 2021 to continue to receive reimbursements from his Medical Flexible Spending Account (under rules similar to the rules applicable to the Dependent Care Spending Account) of unused benefits or contributions through the end of the Plan Year in which such participation ceased (including any grace period).
- For purposes of determining eligible reimbursements from a Participant's Dependent Care Spending Account, in the case of a Participant who qualifies as an "Eligible Employee" (as defined below), a Dependent Care Expense shall be determined by substituting "age 14" for "age 13" in Code Section 21(b)(1)(B) for the "First Plan Year" (as defined below) and, for a "Participant with Unused DCAP" (as defined below), the Second Plan Year.

A "Participant with Unused DCAP" may only take advantage of this rule in the Second Plan Year to the extent of amounts paid for dependent care assistance for a dependent who attains age 13 in the First Plan Year or the Second Plan Year and only to the extent of the Participant's unused Dependent Care Flexible Spending Account balance for the First Plan Year.

- "Eligible Employee" means a Participant who (i) is enrolled in a Dependent Care Flexible Spending Account for the "First Plan Year" (as defined below); and (ii) has one or more dependents (as defined in Code Section 152(a)(1)) who attain the age of 13 during the First Plan Year; or, in the case of a "Participant with Unused DCAP" (as defined below), the subsequent Plan Year.
- The "First Plan Year" means the last Plan Year with respect to which the end of the regular enrollment period for such Plan Year was on or before January 31, 2020.
- The "Second Plan Year" means the Plan Year following the First Plan Year.
- "Participant with Unused DCAP" means a Participant who has an unused Dependent Care Flexible Spending Account balance for the First Plan Year.

This Dependent Care Spending Account change shall apply unless the Employer elects otherwise.

- For Plan Years ending in 2021 and subject to such limitations that are specified by the Employer, a Participant may make an election to modify prospectively the amount of such Participant's contributions to the Participant's Dependent Care Flexible Spending Account or Medical Flexible Spending Account (subject to applicable dollar limitations). Any change allowed shall not permit a revocation or decrease in election below the amount already reimbursed.

The above provisions are qualified by, and subject to, the requirements of the CAA.

- 9.10 CARES Act Changes. Notwithstanding any other provisions in the Plan to the contrary, medicines or drugs that are sold lawfully without a prescription need not be prescribed to qualify as Medical Expense reimbursable under the Plan's General Medical Flexible Spending Account or Limited Medical Flexible Spending Account if the expenses for these items are incurred after December 31, 2019. In addition, expenses for menstrual care products incurred by a Participant or his or her Spouse or Dependents after December 31, 2019, shall qualify as Medical Expenses reimbursable under the Plan's General Medical Flexible Spending Account or Limited Medical Flexible Spending Account.
- 9.11 Contribution/Carryover Limits. Subject to such additional limits that an Employer may impose, contributions and carryovers are subject to all applicable statutory limits.

APPENDIX A

A. Use and Disclosure of Protected Health Information (PHI)

The Plan will use and/or disclose Protected Health Information (“PHI”) to the extent of and in accordance with the uses and disclosures permitted or required by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated pursuant thereto (“HIPAA”), which are hereby incorporated by reference. For example, the Plan may use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

The following terms are defined for purposes of this subsection:

Protected Health Information (“PHI”) is individually identifiable health information, whether oral or recorded in any form or medium, which is collected from an individual, and which:

- Is created or received by the Plan;
- Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
 - a. That identifies the individual; or
 - b. With respect to which there is a reasonable basis to believe that the information can be used to identify the individual; and
- Is transmitted by electronic media, maintained in any electronic medium, or transmitted or maintained in any other form or medium. PHI excludes information in education records covered by the Family Educational Right and Privacy Act, records described at 20 U.S.C. § 1232(g)(a)(4)(B)(iv), and employment records held by the Plan Sponsor in its role as employer.

Electronic Protected Health Information (“e-PHI”) is PHI that is transmitted by electronic media or maintained in any electronic medium.

Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; and the referral of a patient for health care from one health care provider to another.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for the coverage and provision of plan benefits or to obtain or provide reimbursement for the provision of health care that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual’s claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Risk adjusting amounts due based on enrollee health status (not including genetic information) and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

- Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- Utilization review, including precertification, preauthorization, concurrent review and retrospective review; and,
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan).

Health Care Operations include, but are not limited to the following activities:

- Quality assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating and other activities that do not involve consideration of genetic information relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- Business management and general administrative activities of the Plan, including, but not limited to:
 - a. Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or,
 - b. Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
- Resolution of internal grievances;
- The sale, transfer, merger, or consolidation of all or part of the "covered entity" within the meaning of HIPAA with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and
- Consistent with the applicable requirements of the regulations issued under HIPAA, creating de-identified health information or a limited data set and fundraising for the benefit of the "covered entity" within the meaning of HIPAA.

Summary Health Information is information (1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under the Plan; and (2) from which the information described at 42 C.F.R. §164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 C.F.R. § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

Unsecured PHI is PHI that is not secured through the use of technology or methodology specified by the Secretary of Health and Human Services ("HHS").

B. The Plan Will Use and Disclose PHI Consistent with HIPAA's Requirements and as Permitted by Authorization of the Plan Participant or Beneficiary

The Plan will use and disclose PHI consistent with the rules and requirements under HIPAA. To the extent required by HIPAA, the Plan shall obtain a written authorization from the individual who is the subject of the PHI for certain uses and disclosures of PHI.

C. Disclosures to the Plan Sponsor

The Plan will not disclose PHI to the Plan Sponsor unless it receives a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the provisions set forth in Sections D and E below. Notwithstanding the foregoing, the Plan may disclose to the Plan Sponsor the following:

1. The Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of :
 - a. Obtaining premium bids from health plans for providing health insurance coverage under the group health plan; or
 - b. Modifying, amending, or terminating the group health plan.
2. The Plan may disclose to the Plan Sponsor information on whether an individual is participating in the group health plan, or is enrolled in or has disenrolled from a particular coverage option offered by the Plan.

D. Plan Sponsor Covenants Regarding PHI

The Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor through a written contractual agreement in accordance with 45 CFR § 164.314;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- Not use or disclose PHI genetic information for underwriting purposes;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware, including breaches of Unsecured PHI as required by 45 CFR § 164.410, and any other Security Incident of which becomes aware;
- Make PHI available in paper and/or electronic format to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Secretary of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and

- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

E. With Respect to e-PHI, the Plan Sponsor Agrees to the Following Conditions

The Plan Sponsor agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI that it creates, receives, maintains, or transmits on behalf of the Plan, in accordance with HIPAA security rules;
- Ensure that the adequate separation between the Plan and Plan Sponsor is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information as part of its written contractual agreement in accordance with 45 CFR § 164.314;
- Report to the Plan any Security Incident of which it becomes aware. For purposes of this section, Security Incident shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the e-PHI, as well as any probable compromise of Unsecured PHI of which it becomes aware; and
- Upon request from the Plan, Plan Sponsor agrees to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to Plan Sponsor.

Notwithstanding the foregoing, these limitations shall not apply to Enrollment, Disenrollment, and Summary Health Information provided to Plan Sponsor pursuant to 45 CFR § 164.504(f)(1)(ii) or (iii); of e-PHI released pursuant to an Authorization that complies with 45 CFR § 164.508; or in other circumstances as permitted by the HIPAA regulations.

F. Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained

The Plan Sponsor shall permit only those individuals listed below to have access to PHI in order to carry out their duties with respect to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. In the event that the individuals listed below do not comply with this Plan Document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. The Plan Sponsor will ensure that the adequate separation between the Plan and Plan Sponsor is supported by reasonable and appropriate security measures.

The following employees, classes of employees or other persons under the Plan Sponsor's control (or acting on behalf of Plan Sponsor) may have access to PHI:

[Insert in the blanks below the title and/or description of the class of all person(s) expected to have access to PHI]

G. Limitations of PHI Access and Disclosure

The persons described in Section F may only have access to and use and disclose PHI to the extent necessary to perform plan administration functions that the Plan Sponsor performs for the Plan.

H. Noncompliance Issues

If the persons described in Section F do not comply with HIPAA's and the Plan's privacy rules, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

I. Participant Notice

The Plan shall be operated in accordance with the Notice of Privacy Practices, written in accordance with 45 CFR § 164.502, which shall be distributed to Plan Participants and which may be amended from time to time by the Plan Administrator or insurer providing benefits.

J. Health Plan Policies and Procedures

In addition to the policies and procedures set forth in the Participant Notice, the Plan has established the policies and procedures to safeguard the privacy of PHI and comply with HIPAA's requirements. The Plan Administrator may amend such policies and procedures from time to time, as it deems appropriate.

K. Policy and Procedure for Notification of Breach of Unsecured Protected Health Information

The Plan and its contractors will strive to prevent breaches of Unsecured PHI electronically or otherwise, and maintain privacy and security measures to protect the confidentiality of PHI. Pursuant to HIPAA and Regulations promulgated thereunder, and the Health Information Technology for Economic and Clinical Health Act ("HITECH"), the Plan will notify individuals if there is a probable compromise of Unsecured PHI.

Background and Purpose:

Pursuant to HIPAA and Regulations promulgated thereunder, and the Health Information Technology for Economic and Clinical Health Act ("HITECH"), the Plan will notify individuals when Unsecured PHI has been acquired, accessed, used or disclosed by an unauthorized person, when a confirmed breach of the security of the system does not fall within a statutory exception or there is a low probability that the PHI has been compromised.

Policy:

Confirmed breaches of the security or privacy of Unsecured PHI will invoke certain actions to determine the probability that the PHI has been compromised based on a risk assessment and, under specific circumstances, notification of the breach will be made to the affected individual(s).

Procedure for Notification:

- a. The Plan has implemented reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of PHI and PI in its possession.
- b. The Plan has implemented reasonable systems for the discovery and reporting of a breach of PHI or PI. A "breach" of PHI is the unauthorized acquisition, access, use or disclosure of PHI which compromises the security or privacy of the PHI.
- c. When a breach has been reported, an investigation into the breach will be conducted.

- d. The investigation and steps taken will be thoroughly documented. If the conclusion of the investigation is that no breach occurred, no further action is necessary, but the investigation and conclusion will be thoroughly documented.
- e. If it is confirmed that a breach of security or confidentiality has occurred and has resulted in the unauthorized disclosure of PHI, the following risk assessment steps will be taken:
 - 1. Determine whether or not the information breached was Unsecured. Unsecured PHI includes information not secured through encryption or destruction, and is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary of HHS in guidance issued under Section 13402(h)(2) of Public Law 111-5.
 - 2. Determine the reasonable likelihood that such information was accessed by an unauthorized person.
 - 3. Determine the probability that the PHI has been compromised based on a risk assessment of at least the following factors: (i) the nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used the PHI or to whom the disclosure was made; (iii) whether the PHI was actually acquired or viewed; and (iv) the extent to which the risk to the PHI has been mitigated.
- f. The risk assessment will be documented thoroughly, including the actions taken, the conclusions of the assessment and the basis for the determination that there was or was not a low probability that the PHI was compromised.
- g. If it is determined that the information breached was secured and there is no reasonable likelihood that the secured information was rendered usable, readable or viewable by an unauthorized person, no further action is necessary, but the determination and conclusion will be documented.
- h. If it is determined that the information breached was Unsecured, but the circumstance of the breach falls within one of the exceptions to HIPAA (45 CFR § 164.402) so notification is not required, such determination will be documented.
- i. If it is determined that the breach of the security of the system demonstrates that there is more than a low probability that the PHI was compromised, the Plan will as soon as possible, but no later than sixty (60) days after the discovery of the breach, notify the individual(s) whose information was disclosed as a result of the breach and the determination and conclusion will be documented.
- j. If it is determined that the information breached was Unsecured and notification is required, an analysis of the requirements for notification of the State in which the individuals reside will be conducted and documented.
- k. If notification to law enforcement or another regulatory body or agency is required under State law such notification will be made to the regulatory body or agency in accordance with State law.
- l. If State law requires notification to the individual, notification will be made in accordance with State law.
- m. Notification to the individual may be delayed if a law enforcement agency determines that the notification will impede a criminal investigation and the notification will be made after law enforcement determines it will not compromise its investigation.
- n. Notification of a breach to affected individuals will be in plain language and include at a minimum:
 - 1. A brief description of what happened, including the date of the breach and discovery of the breach; a description of the type of Unsecured PHI or other personal information that was involved in the breach;
 - 2. Any steps individuals should take to protect themselves from potential harm resulting from the breach;
 - 3. A description of the investigation into the breach, mitigation of harm to individuals, and protection against further breaches; and

4. Contact procedures, which will include a toll-free telephone number, an e-mail address, website or postal address.
 - o. The notification must include any additional information required by applicable State law.
 - p. If the breach involves more than 500 residents of a state or jurisdiction, notice will be provided to the media and to the Secretary of the Department of Health and Human Services contemporaneously.
 - q. A log of any and all breaches of Unsecured PHI of less than 500 individuals will be maintained and reported to the Secretary of HHS on an annual basis.
 - r. Business Associates and vendors, through their contracts and/or Business Associate Agreements with the Plan will be required to provide notification of a breach to the Plan so that affected individuals can be notified, as necessary. Business Associates must provide all available information without delay.
 - s. Documentation will be maintained of each individual notified, each notification provided to HHS and any other notification to the Secretary of HHS as required by law.

RECORD OF ADOPTION

By signing this Record of Adoption, the Employer approves and adopts the terms of the Flexible Benefit Plan as stated in the Plan Document and Plan Highlights. A copy of the current Plan Highlights is attached to this Plan and Record of Adoption and incorporated herein by reference.

(Date)

(Name)

(Title)

Appendix D: Notice of HIPAA Privacy Practices

Purpose: Privacy notices must be given to individuals covered by the plan. A single notice to a covered employee is effective for all covered dependents. Notices must be provided upon enrollment, and within 60 days of a material change to the notice. Plans must notify participants every 3 years that a privacy notice is available. Consistent with other template forms, this Notice assumes the plan does not, with respect to protected health information: (1) engage in fundraising; (2) engage in marketing, where the plan receives financial remuneration for such marketing; (3) sell protected health information; (4) use genetic information for underwriting purposes; or (5) engage in research. If these assumptions are not correct this Notice should be changed.

University of San Francisco

PRIVACY PRACTICES NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Summary of Our Privacy Practices

We may use and disclose your protected health information ("medical information"), without your permission, for treatment, payment, and health care operations activities. We may use and disclose your medical information, without your permission, when required or authorized by law for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your care or payment for your health care. We may disclose your medical information to appropriate public and private agencies in disaster relief situations.

We may disclose to your employer whether you are enrolled or disenrolled in the health plans it sponsors. We may disclose summary health information to your employer for certain limited purposes. We may disclose your medical information to your employer to administer your group health plan if your employer explains the

limitations on its use and disclosure of your medical information in the plan document for your group health plan.

Except for certain legally-approved uses and disclosures, we will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information. You have the right to receive an accounting of certain disclosures we may make of your medical information. You have the right to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

You have the right to receive notice of breaches of your unsecured medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints

regarding or additional information about our privacy practices.

Contact Information

For more information about our privacy practices, to discuss questions or concerns, or to

get additional copies of this notice, please contact our Contact Office.

Contact Office: Director of Employee Benefits

Telephone: (415) 422-2442

Address: 2130 Fulton Street, San Francisco, CA 94117

{Insert the following section if this is a "joint notice" for an "organized health care arrangement."}

Health Plans Covered by this Notice

This notice applies to the privacy practices of the health plans listed below. They may share with each other your medical information, and the Kaiser HMO (N. CA, S. CA, Hawaii)

medical information of others they service, for the health care operations of their joint activities.

Anthem Blue Cross PPO, HSA

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information ("medical information"). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect January 1, 2026, and will remain in effect unless we replace it.

Uses and Disclosures of Your Medical Information

Treatment: We may disclose your medical information, without your permission, to a physician or other health care provider to treat you.

your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the subscriber of the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or another health plan

Payment: We may use and disclose your medical information, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine

for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your medical information, without your permission, for health care operations. Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar reinsurance for our health coverage obligations; and
- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We generally may use or disclose any

psychotherapy notes we hold only with your authorization.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing medical information related to your care or payment is in your best interest under the circumstances.

Your medical information remains protected by us for at least 50 years after you die. After you die, we may disclose to a family member, or other person involved in your health care prior to your death, the medical information that is relevant to that person's involvement, unless doing so is inconsistent with your preference and you have told us so.

Your Employer : We may disclose to your employer whether you are enrolled or disenrolled in a health plan that your employer sponsors.

We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan (this is sometimes called "underwriting"). Summary health information is aggregated claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although summary health information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical information contained in the summary health information as yours. We are expressly

prohibited from using or disclosing any health information containing your genetic information for underwriting purposes.

We may disclose your medical information and the medical information of others enrolled in your group health plan to your employer to administer your group health plan. Before we may do that, your employer must amend the plan document for your group health plan to establish the limited uses and disclosures it may make of your medical information. Please see your group health plan document for a full explanation of those limitations.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services that we provide or include in our benefits plan. We may use your medical information to communicate with you about treatment alternatives that may be of interest to you.

These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to our benefits plans.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Your Rights

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You should submit your request **in writing** to our Contact Office.

We may charge you reasonable, cost-based fees (including labor costs) for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Contact Office for information about our fees.

Your medical information may be maintained electronically. If so, you can request an electronic copy of your medical information. If you do, we will provide you with your medical information in the electronic form and format you requested, if it is readily producible in such form and format. If not, we will produce it in a readable electronic form and format as we mutually agree upon.

You may request that we transmit your medical information directly to another person you designate. If so, we will provide the copy to

the designated person. Your request must be in writing, signed by you and must clearly identify the designated person and where we should send the copy of your medical information.

Disclosure Accounting: You have the right to a list of instances from the prior six years in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the contact at the end of this notice. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before the plan's effective date (if the plan was created less than six years ago).

Amendment. You have the right to request that we amend your medical information. You should submit your request **in writing** to the contact at the end of this notice.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request, except for certain required restrictions, described below. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the end of this notice. We will agree to (and not terminate) a restriction request if:

1. the disclosure is to a health plan for purposes of carrying out payment or health care

operations and is not otherwise required by law; and

2. the medical information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. **You should make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request.** You should submit your request **in writing** to the contact at the end of this notice.

We will accommodate your request if it is reasonable, specifies the means or location for communicating with you, and continues to permit us to collect premiums and pay claims under your health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Notification may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Contact Office to obtain this notice in written form.

Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may complain to our Contact Office.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Appendix E: Authorized Representatives

Appointment of Authorized Representative

I, _____

[name of claimant]

hereby appoint _____ to act on my behalf

[name of Authorized Representative]

or on behalf of _____

[name of patient: plan participant or beneficiary]

in connection with any claim for coverage or benefits, including receipt of any approvals or authorizations that are required before medical services are provided under the plan named above ("Plan"). I authorize my representative to receive any and all information that is provided to me, and to act for me and for my covered spouse or dependent, if named above as the patient, in providing any information to the Plan that relates to any claim for coverage or benefits under the Plan.

This form does not constitute an assignment of rights for direct payment.

Distribute to me and to my Authorized Representative: All information and notifications should be distributed to me and to my Authorized Representative.

Claimant's signature

Date

Accepted: _____

Authorized Representative's signature

Date

Witness: _____

Witness signature

Date

**Summary of Material Modification
To
University of San Francisco Welfare Benefit Plan**

To: Employee participants in the University of San Francisco Welfare Benefit Plan and COBRA participants

From: Human Resources

Date: January 1, 2026

The University of San Francisco Welfare Benefit Plan sponsored by University of San Francisco has been revised. All of the changes summarized below are effective January 1, 2026.

1. Healthcare FSA limit increased to \$3,400.
2. Transit (Commuter / Parking) limit increased to \$340.
3. Dependent Care FSA limit increased to \$7,500 (\$3,750 if married and filing separately).
4. Employee contributions for 2026 have increased. Please refer to your 2026 benefit guide for exact increases by plan and salary band. See Appendix A for monthly contributions and salary bands.

Please contact the Director of Employee Benefits (acting on behalf of the plan administrator, University of San Francisco), if you have questions regarding the information in this SMM. They can be reached as follows:

Phone: (415) 422-2442

E-mail: benefits@usfca.edu

Address: 2130 Fulton Street, San Francisco, CA 94117

FILING INSTRUCTIONS

Please keep this memorandum with your copy of the Plan's Summary Plan Description (SPD), as it explains important changes that may affect your benefits (please contact the Director of Employee Benefits if you need another copy of the SPD, which can also be found on the Benefits Compliance Documents page on myUSF).

ERISA INFORMATION

Plan Sponsor: University of San Francisco

Sponsor's EIN#: 27-0494101

Plan Name: University of San Francisco Welfare Benefit Plan

Plan Number: 501

Plan Year: 2026

Appendix A: 2026 Monthly Contribution Rates

Salary Bands & Rates		Anthem Blue Cross PPO			
		Total Rates	Your Contribution	USF's Contribution	COBRA Rates
<\$72,446	Employee only	\$1,811.26	\$72.00	\$1,739.26	\$1,847.49
	Employee + one	\$3,819.56	\$262.00	\$3,557.56	\$3,895.95
	Employee + family	\$5,458.68	\$429.00	\$5,029.68	\$5,567.85
\$72,447–\$108,075	Employee only	\$1,811.26	\$89.00	\$1,722.26	\$1,847.49
	Employee + one	\$3,819.56	\$336.00	\$3,483.56	\$3,895.95
	Employee + family	\$5,458.68	\$538.00	\$4,920.68	\$5,567.85
\$108,076–\$144,891	Employee only	\$1,811.26	\$104.00	\$1,707.26	\$1,847.49
	Employee + one	\$3,819.56	\$414.00	\$3,405.56	\$3,895.95
	Employee + family	\$5,458.68	\$640.00	\$4,818.68	\$5,567.85
\$144,892–\$179,333	Employee only	\$1,811.26	\$125.00	\$1,686.26	\$1,847.49
	Employee + one	\$3,819.56	\$449.00	\$3,370.56	\$3,895.95
	Employee + family	\$5,458.68	\$739.00	\$4,719.68	\$5,567.85
\$179,334–\$216,150	Employee only	\$1,811.26	\$175.00	\$1,636.26	\$1,847.49
	Employee + one	\$3,819.56	\$636.00	\$3,183.56	\$3,895.95
	Employee + family	\$5,458.68	\$1,072.00	\$4,386.68	\$5,567.85
\$216,151+	Employee only	\$1,811.26	\$212.00	\$1,599.26	\$1,847.49
	Employee + one	\$3,819.56	\$749.00	\$3,070.56	\$3,895.95
	Employee + family	\$5,458.68	\$1,288.00	\$4,170.68	\$5,567.85

Salary Bands & Rates		Kaiser Permanente HMO			
		Total Rates	Your Contribution	USF's Contribution	COBRA Rates
<\$72,446	Employee only	\$975.22	\$58.00	\$917.22	\$994.72
	Employee + one	\$1,950.44	\$234.00	\$1,716.44	\$1,989.45
	Employee + family	\$2,759.88	\$274.00	\$2,485.88	\$2,815.08
\$72,447–\$108,075	Employee only	\$975.22	\$70.00	\$905.22	\$994.72
	Employee + one	\$1,950.44	\$250.00	\$1,700.44	\$1,989.45
	Employee + family	\$2,759.88	\$327.00	\$2,432.88	\$2,815.08
\$108,076–\$144,891	Employee only	\$975.22	\$79.00	\$896.22	\$994.72
	Employee + one	\$1,950.44	\$288.00	\$1,662.44	\$1,989.45
	Employee + family	\$2,759.88	\$407.00	\$2,352.88	\$2,815.08
\$144,892–\$179,333	Employee only	\$975.22	\$87.00	\$888.22	\$994.72
	Employee + one	\$1,950.44	\$316.00	\$1,634.44	\$1,989.45
	Employee + family	\$2,759.88	\$470.00	\$2,289.88	\$2,815.08
\$179,334–\$216,150	Employee only	\$975.22	\$114.00	\$861.22	\$994.72
	Employee + one	\$1,950.44	\$441.00	\$1,509.44	\$1,989.45
	Employee + family	\$2,759.88	\$627.00	\$2,132.88	\$2,815.08
\$216,151+	Employee only	\$975.22	\$142.00	\$833.22	\$994.72
	Employee + one	\$1,950.44	\$537.00	\$1,413.44	\$1,989.45
	Employee + family	\$2,759.88	\$761.00	\$1,998.88	\$2,815.08